83-831

No.

In The

Supreme Court of the United States

October Term 1983

LAURENCE STUEBIG, a/k/a LAWRENCE STUEBIG, by his Guardian, MARIE CAROLE HECKMANN, 251 N. Bent Road, Wyncote, Pennsylvania, 19095,

Petitioner,

v.

BERNARD J. WILLIS, M.D., Acting Superintendent and Clinical Director of Farview State Hospital For the Criminally Insane, Waymart, Pa.

and

JOHN P. SHOVLIN, M.D., 20 Dendrick Lane, Carbondale, Pa.

and

JOHN M. FITZGERALD, Director of Social Services of Farview State Hospital for the Criminally Insane, Waymart, Pa.

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTIONS PRESENTED FOR REVIEW

1. Whether when a § 1983 plaintiff's constitutional rights to life and liberty under the Fourteenth Amendment are clearly violated and when the state mental institution officials' duty to review the patient's status and to treat him are clearly mandated by the Court Order committing him and also by state statutory law, good faith immunity may be granted to the state officials who failed to review and treat the § 1983 plaintiff.

2. Whether in a § 1983 action, where a plaintiff's constitutional rights have clearly been violated by the knowing disregard of state officials, may the plaintiff be denied recovery on the grounds that he failed to prove malicious intention to cause injury and has failed to rebut an asserted presumption of good faith.

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Petitioner, Laurence Stuebig, by his guardian, Marie Carole Heckmann, respectfully prays that a writ of certiorari be issued to review the judgment of the United States Court of Appeals for the Third Circuit, entered in this proceeding on August 18, 1983.

REFERENCE TO OPINIONS BELOW

The opinion of the District Court, denying respondents' motion to dismiss, reported at 446 F. Supp. 31 (M.D. Pa. 1977), is set forth in the Appendix.

The memorandum and order of the District Court entering judgment for defendants, which is not reported, is set forth in the Appendix. The order of the District Court denying petitioner's motion for a new trial, which is not reported, is also set forth in the Appendix.

The opinion of the Court of Appeals for the Third Circuit, which is not reported, is set forth in the Appendix.

STATEMENT OF GROUNDS FOR JURISDICTION

The judgment of the Court of Appeals for the Third Circuit was entered on August 18, 1983. This petition is filed within 90 days of that date pursuant to 28 U.S.C. § 2101(c).

This Court has jurisdiction to review the judgment of the Court of Appeals for the Third Circuit by writ of certiorari pursuant to the provisions of 28 U.S.C. § 1254(1).

CONSTITUTIONAL PROVISION INVOLVED

Fourteenth Amendment § 1

"Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they

reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; deny to any person within its jurisdiction the equal protection of the laws."

STATEMENT OF THE CASE

This is an action for money damages brought by the petitioner Laurence Stuebig ("Stuebig"), by his guardian, Marie Carole Heckmann, pursuant to the Civil Rights Act of 1871, 42 U.S.C. § 1983, in which Stuebig claimed that respondents, officials at Farview State Hospital ("Farview"), violated his constitutional rights by neither releasing him or treating him during the 35 years he was held at Farview. The district court held that although Stuebig's constitutional rights were clearly violated by respondents, they were immune from liability for damages. The Court of Appeals for the Third Circuit affirmed.

But to state that this is a § 1983 action, and that respondents prevailed below, is to minimize the incredible nature of this case. Research has failed to reveal any other case in which an individual has been so thoroughly, completely and totally deprived of his constitutional rights and has been afforded no redress for the wrongs done to him. Petitioner Stuebig was incarcerated in a maximum security prison for 35 years—a state mental hospital for the criminally insane to which the most hardened criminals are sent from other prisons. This pun-

ishment was imposed on him by respondents despite the fact that he was never declared insane, nor was he ever found to be a danger to himself or others.

The facts giving rise to this unbelievable case began more than four decades ago on January 16, 1941, when Stuebig was found sleeping in a railroad boxcar in Philadelphia. He was arrested for vagrancy and trespassing and was later charged with burglary with the intent to steal boxes of candy valued at under $250.00 Stuebig's alleged accomplice was sentenced to nine months in the county prison. Following his arrest, Stuebig was examined by a "lunacy commission" consisting of two physicians and an attorney. The commission concluded that Mr. Stuebig was suffering from delusions, exihibited paranoic tendencies, and recommended that he be committed for observation.

The Quarter Sessions Court of Philadelphia County followed the lunacy commission's recommendation, concluding that Stuebig was not competent to stand trial, and ordered him committed to Farview State Hospital for the Criminally Insane. By court order dated February 6, 1941, Stuebig was to be "detained and treated" at Farview.

What followed, however, was not detention and treatment, but rather a shocking offense to Stuebig's fundamental rights and to his dignity as a human being. On February 15, 1941, Stuebig began his incarceration at Farview State Hospital. He was there held and abandoned for thirty-five years. He received no psychiatric or psychological examination or evaluation by anyone competent to perform such an examination or evaluation

until May 22, 1975. He never went to a staff evaluation. He never received psychotherapy or psychotropic drug therapy. In short, he received no psychiatric treatment at all.

It was never urged nor argued by Farview authorities that he was dangerous to himself or others. With a modicum of available treatment, he would have quickly become competent to stand trial and no longer mentally ill. The electro-shock therapy of the 1940's and the psychotropic drugs and activities therapies of the 1950's would have quickly restored Stuebig to full mental health. The uncontradicted evidence at trial showed that even without treatment, Stuebig was competent to stand trial as early as 1941.

Rather than receiving the review and treatment which would have led to his release, Stuebig languished as a prisoner in confinement for so long at Farview that he suffered permanent mental deterioration due to chronic institutionalization, Alzheimer's Disease, and untreated schizophrenia.

It was not until 1975 that Stuebig was finally examined and subsequently released. His examination took place after a telephone call in 1975 from an old friend of his inquiring about his status. Prior to that telephone call a bulletin had been issued by the Department of Public Welfare in 1973 which prescribed procedures to review the status of persons committed on the ground that they were incompetent to stand trial. Because of the large number of patients at Farview who needed to be evaluated, and the paucity of trained psychiatrists at Farview, outside phychiatrists had to be brought in to con-

duct the reviews. However, patients about whom inquiries were made were examined first. The psychiatrist who finally examined Stuebig pronounced him fit for release.

The respondents, Dr. John P. Shovlin ("Shovlin"), Dr. Bernard J. Willis ("Willis") and John M. Fitzgerald ("Fitzgerald"), were responsible for the review and treatment of inmates at Farview, but failed to take such action despite the knowledge that it would cause injury to Stuebig and others. Dr. Shovlin was superintendent at Farview from 1949 to 1974, assistant superintendent between 1946 and 1949, and a ward physician from 1937 to 1941. Dr. Willis was a medical staff member at Farview in 1955 who became Clinical Director in the late 1950's and remained in that post until 1977. John M. Fitzgerald was the Director of Social Services at Farview beginning in 1971.

The federal constitutional issues which are the subject of this petition address the liability of these respondents, or more specifically, the propriety of cloaking the respondents in a qualified immunity based upon their reasonable good faith.

After trial, the district court found that petitioner's constitutional rights had clearly been violated. Specifically, the district court found that defendants Dr. John P. Shovlin, Superintendent at Farview, and Dr. Bernard J. Willis, Clinical Director, did have "knowledge that their actions would injure the plaintiff and others at Farview." The court held that the failure of respondents Shovlin and Willis to institute systematic procedures by which to enforce a policy calling for the aggressive use of psychoactive drugs personally violated Stuebig's con-

stitutional rights. With respect to respondent Fitzgerald, the court held that because he was responsible for reviewing patients' commitment status, he was responsible for Stuebig's not being released or evaluated prior to 1975.[1]

But the District Court failed to focus on the petitioner's rights under the court order. Petitioner submits that there was an affirmative duty imposed by that order to keep the court advised of Stuebig's status. Their failure to do so constituted cruel and unusual punishment in violation of the Eighth Amendment as well as a denial of his rights under the Fifth and Sixth Amendments. Stuebig, because of respondents' malfeasance, lost his rights to a speedy trial, to face his accusers and to be tried by a jury of his peers, before being found guilty and in effect receiving a life sentence for a crime for which he had not been tried. In short, Stuebig was deprived of the most fundamental rights accorded to all American citizens, solely because of the actions and inactions of the respondents.

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1 The respondent's inaction was in violation of state statutory law, which imposed an affirmative duty on Fitzgerald to review the status of patients at Farview. The Mental Health and Retardation Act of 1966, P.L. 96, art. IV, § 409(b) as amended 50 P.S. § 4409(b) provides in part:

> "If such a person shows a sufficient improvement of condition so that his continued commitment is no longer necessary, he shall be returned to the court having jurisdiction of him for trial or such other disposition of such charges as the court shall make. As stated above, respondent's failure to act was also in violation of the court order committing Stuebig to Farview."

But the Court did find that respondents, Shovlin, Willis and Fitzgerald had violated Lawrence Stuebig's Fourteenth Amendment rights because of the unauthorized confinement of Stuebig "during the 1940's and early 1950's when no effective treatment was available and during the late 1950's and 1960's when no effort was made to provide treatment."[2] Nevertheless, the district court refused to hold any respondent liable. The district court stated that the respondents acted in both objective and subjective good faith because they did not violate a clearly established right to treatment of the plaintiff and that respondents Willis and Shovlin "established that they con-

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2 State statutory law imposed an affirmative duty upon state hospital officials to provide psychiatric treatment to patients. These expectations created by state law are entitled to protection under the Due Process Clause of the Fourteenth Amendment. *Board of Regents v. Roth*, 408 U.S. 564, 577 (1972); *Wolff v. McDonnell*, 418 U.S. 539, 557-558 (1974); *Meachum v. Fano*, 427 U.S. 215 (1976). The Mental Health Act reads, in part:

> "Care shall include reception, detention, custody, care, treatment, maintenance, support, segregation, education, culture, training, discipline, improvement occupation, employment, medical and surgical treatment and nursing, food and clothing.

The Mental Health Act of 1923, Art. I § 162, Pub. L. 414, 1923 Pa. Laws 998,999.

The 1951 Act Reads, in pertinent part:

> "Care shall include reception, detention, transfer, parole, discharge, custody, care, treatment, education, culture, training, discipline, improvement, occupation, employment, medical and surgical treatment, and nursing, food and clothing.

The Mental Health Act of 1951, Art I, § 102(1), Pub. L. 141, 1951 Pa. Laws 533, 538.

The district court concluded that these provisions incorporate the concept of psychiatric treatment.

ducted themselves in subjective good faith." Further, the court concluded that Stuebig had failed to prove the malicious intent of respondent Fitzgerald.

Despite the respondents' knowing disregard of petitioner Stuebig's life and liberty, the district court chose to relieve them of any and all liability. The court expressed the view that:

> "[T]his civil rights action focuses not upon the fairness and humanity of the treatment plaintiff received at the hands of the Commonwealth of Pennsylvania, but rather on the propriety of assessing damages against the . . . individual agents of the Commonwealth. . . ."

A panel of the United States Court of Appeals for the Third Circuit affirmed the decision of the district court. The Court of Appeals held that the district court did not err in applying the law of qualified immunity, on the grounds that respondents were immune from personal liability for damages because they neither knew nor reasonably should have known that their failure to supervise various therapeutic programs would violate Stuebig's rights and that they did not maliciously intend to cause Stuebig's injuries.

Thus, the incredible indeed happened. An individual was indicted on a simple criminal charge, examined by a lunacy commission and committed to a mental institution. There he was jailed virtually for life without ever having been convicted of a single criminal act and those whose knowing violation of his constitutional rights and breach of duty brought about this catastrophic injury were found to be blameless and excused from all liability.

REASONS FOR GRANTING THE WRIT

I. The Decisions Below Erroneously Applied The Qualified Immunity Defense, In Failing To Give Proper Effect To The Notice Of The Petitioner's Right To Treatment Provided To Respondents By State Law And Court Order.

Having found constitutional violations of petitioner's rights, the district court went on to consider the issue of qualified immunity. Incredibly enough, the district court held that respondents were immune from personal liability for damages because they neither knew nor should have known that their inaction would violate Stuebig's rights. Further, the court held that the defendants did not maliciously intend to cause Stuebig's injury. The district court determined that respondents Shovlin and Willis could not reasonably have been expected to know that the United States Constitution, viewed in isolation, barred their disregard of Stuebig's right to life and liberty. Therefore, the court concluded they were entitled to good faith immunity.[3]

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3 The decisions of this Court recognize a qualified immunity based upon reasonable good faith of state officials where the rights violated by state officials had not been clearly established at the time of their infringement. *Harlow v. Fitzgerald,* — U. S. —, 102 S. Ct. 2727, 2739 (1982). The policy reason for cloaking state government officials with protection from the claims of those who feel themselves adversely affected by their actions is to facilitate the discharge of their discretionary duties, thereby allowing officials to act and speak freely. *Gregoire v. Biddle,* 177 F. 2d 579, 580 (2nd Cir. 1949).

But this concept of immunity means nothing more than that public officials should have fair warning that certain rights of individuals must be respected before they can be held

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Respondents have argued successfully below that they were acting in a discretionary rather than a ministerial capacity, and that for this reason they were entitled to the protection of the qualified immunity defense. In effect, respondents have claimed the right to act as judge, jury and executioner. They have argued that they were entitled to keep petitioner Stuebig in a maximum security prison for 35 years on the basis of a single commitment paper; a paper which directed them to *treat* and *review* Stuebig. Respondents have argued, and the courts so far have agreed, that they had not the slightest reason to suspect that they were trespassing on the petitioner's rights as a human being. It surpasses belief that the respondents could honestly think that they could completely ignore the direction to evaluate the petitioner so he could be returned to court for trial. But respondents *had no discretion*; in failing to evaluate Stuebig, they failed to carry out an affirmative duty imposed on them by the court order and thus, petitioner submits, the issue of qualified immunity should never have arisen.

But the district court declined to give any weight to the notice to respondents of Stuebig's legal rights under the court order of February 6, 1941 from the Quarter Sessions Court of Philadelphia directing that Stuebig be "detained and *treated* as an insane person" at Farview.

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liable for civil damages. As this court recently held, " . . . government officials performing discretionary functions are shielded from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person should have known." (citations omitted) *Harlow v. Fitzgerald*, — U. S. —, 102 S. Ct. at 2738.

Further, the district court did not consider the notice provided by the Mental Health Acts of 1923 and 1951 which imposed an affirmative duty on state mental hospital officials to care for patients, a duty which clearly incorporates the concept of psychiatric treatment. Further, the Mental Health and Retardation Act of 1966, *as amended* 50 P. S. § 4109(b), places an affirmative duty on hospital officials to review the status of patients in order that they should be returned to the court having jurisdiction over them for disposition of criminal charges pending against them, upon a showing of improvement in their psychiatric condition.[4]

Petitioner submits that even if the constitutional rights of a state mental hospital patient had not been established at the time of their infringement, in determining if a state official deserves the cloak of immunity, a court must consider whether state officials contravened state statutory laws, regulations or court orders. *Williams v. Treen*, 671 F. 2d 812, 899 (5th Cir. 1982) *cert. den.* 103 S. Ct. 672 (1983). Cf. *Parksdale v. King*, 699 F. 2d 744 (5th Cir. 1983); *Williams v. Board of Regents*, 629 F. 2d 993, 1000 (5th Cir. 1980); *Williams v. Edwards*, 547 F. 2d 1206, 1210 (5th Cir. 1977); *Ingenito v. Dept. of*

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4 Where, as here, state mental hospital officials fail to discharge their duties pursuant to state statutory law and state court orders of commitment, this protection from liability is neither necessary nor justifiable. "If the law was clearly established, the immunity defense ordinarily should fail, since a reasonably competent public official should know the law governing his conduct." *Harlow v. Fitzgerald*, 102 S. Ct. at 2739. "It is not unfair to hold liable the official . . . who should know he is acting outside the law." *Butz v. Economou*, 438 U. S. 478, 506 (1978). See also, *S. Nahmod, Civil Rights and Civil Liberties Litigation*, 230, 234 (1974).

Corrections, State of New Jersey, 568 F. Supp. 946, 955 (D. N. J. 1983); *Lowe v. Carter*, 554 F. Supp. 831 (E. D. Mich. 1982); *S. Nahmod, Civil Rights and Civil Liberties Litigation*, 230, 234 (1974).

The Fifth Circuit Court of Appeals has ruled that an official who violates clearly established state law is not entitled to invoke the good faith immunity defense in a § 1983 civil rights action.[5] In *Williams v. Treen*, 671 F. 2d

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5 The Federal Courts of Appeals and the Federal District Courts which have considered this issue are in conflict with the decision of the Third Circuit herein. *Williams v. Treen*, 671, F. 2d 892 (5th Cir. 1982) *cert. den.* 163 S. Ct. 672 (1983) (a state official who knowingly violates clearly established state law violates the objective prong of the good faith immunity defense), *Chavis v. Rowe*, 643 F. 2d 1281 (7th Cir. 1981). (Prison officials are not entitled to claim immunity in § 1983 action where prison regulations gave officials adequate notice that their failure to give prisoner a written statement of evidence relied on and the reasons for disciplinary proceedings deprived inmate of his constitutional rights), *Ingenito v. Dept. of Corrections, State of New Jersey*, 568 F. Supp. 946 (D. N. J. 1983) (state prison officials are not immune to § 1983 action alleging failure to compensate inmates for work performed as required by state law where reasonable persons in defendants' positions as correctional officials should have known of state regulations requiring such compensation. The court recognized that the *Harlow* standard of qualified immunity applies in § 1983 actions and that state officials cannot claim immunity where they violate clearly established state law because " . . . it would be untenable to draw a distinction for purposes of immunity law between suits brought against state officials under § 1983 suits and suits brought directly under the Constitution against federal officials, *Butz v. Economou*, 438 U.S. [478] at 504." *Id.* at 951.) *Lowe v. Carter*, 554 F. Supp. 831 (E.D. Mich., 1982) (prison officials cannot claim immunity in § 1983 action where their conduct violates an inmate's liberty interest created by prison regulations which a reasonable Corrections Department official should have been aware.) See also *Strachan*

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892 (1982) *cert. den.* 103 S. Ct. 672 (1983) that court stated that:

> ". . . 'officials are charged with knowledge of their own regulations.' *Chavis v. Rowe,* 643 F. 2d 1281, 1289 (7th Cir. 1981) . . . If an official's conduct contravenes his own state's explicit and clearly established regulations, a subjective belief in the lawfulness of his action is per se unreasonable . . . the defendants are not entitled to claim immunity based on reasonable good faith. To hold otherwise would be to encourage official ignorance of the law." *Id.* at 899-900.

Where constitutional rights protected by state statutory law are infringed upon by state officials, a party's cause of action should not be defeated by a qualified immunity based upon a reasonable good faith belief in the validity of those actions, when the official's conduct violates clearly established state law regulating that conduct. *Williams v. Treen,* 671 F. 2d at 899 (5th Cir. 1982).

To allow such a result, as permitted by the District Court and affirmed by the Court of Appeals, would obfuscate the rationale for granting the protection of a qualified immunity: to protect the public by allowing government officials to perform their official duties without fear that a good faith exercise of discretion might in retrospect be found to be in error. *Gregoire v. Biddle, supra.* Where,

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v. Ashe, 548 F. Supp. 1193, 1205 (D. Mass. 1982) (prison officials are not entitled to immunity in § 1983 action where an inmate's constitutional right to adequate and hygenic means to dispose of his bodily wastes was clearly established at the time of the infringement of that right and existing state regulations codifying those rights provided notice to prison officials.)

as here, a state official violates clearly established state laws regulating his conduct, he cannot reasonably believe in the validity of that conduct. Certainly, state government officials are charged with knowledge of the regulations which set forth their obligations and duties. *Williams v. Treen*, 671 F. 2d at 899-900; *Ingenito v. Dept. of Corrections, State of N. J.*, 568 F. Supp. at 955. Moreover, since state mental hospital patients are handicapped by mental disease, which renders them unable to understand or exercise their rights concerning their treatment, it is imperative that state hospital officials perform faithfully the duties imposed upon them by state court orders and statutory provisions, cf. *Vitek v. Jones*, 445 U. S. 480, 496 (1980); *Wolff v. McDonnell*, 418 U. S. 539, 569-570 (1974). Therefore, failure to conform with those statutory duties is *per se* unreasonable. *Williams v. Treen*, 671 F. 2d at 899.

In response to the respondents' argument that the provisions of the Mental Health Act impose no duty on the personnel in a mental institution to administer psychiatric treatment, Judge Nealon stated:

> "[T]hat the Commonwealth of Pennsylvania would include psychiatric treatment in its definition of 'care', define 'mental hospitals' as facilities for the 'care' of the mentally ill and yet not contemplate providing care, including psychiatric treatment, is an insupportable proposition which I reject."

Thus, petitioner Stuebig submits that the district court erred in failing to recognize that, in light of the court's order for commitment, requiring review and treatment, and the state mental health statutes, these officials must have known of their duty to review and treat petitioner Stuebig.

II. Contrary To Decisions Of This Court, The Decisions Below Erroneously Imposed Upon The Petitioner The Burden Of Proving Malicious Intention As A Prerequisite To Recovery.

The district court held that the respondents' claim of immunity "places the burden on plaintiff of offering evidence that the defendants intended to injure him." The imposition upon plaintiff of the burden to prove malicious intention, however, contradicts the Supreme Court's most recent pronouncement in *Parratt v. Taylor*, 451 U. S. 1908 (1981). Section 1983 has never been interpreted to require proof of state of mind and certainly not of malicious intent. Acting upon this misconception, the district court exonerated respondent Fitzgerald, director of social services at Farview. The court did this although Fitzgerald had a specific duty to review plaintiff's committment from 1971 on but *never* did so. This was done because petitioner's evidence, as seen by the district court, did not raise "an issue of malice." *Id.*

The court also erroneously exonerated respondents Shovlin and Willis, the chief officials at Farview, despite their knowing disregard of Stuebig's life and liberty. As to these respondents, the district court found that petitioners evidence did raise a "presumption" of deliberate indifference sufficient to oblige defendants Shovlin and Willis to "disprove malicious intention." But the district court then found that these defendants had met their burden because "[u]nless a defendant wielded authority so as 'to inflict harm for reasons unrelated to the performance of [his] duties,' . . . the court should not reject the asserted immunity." These conclusions directly contradict both the facts and the case law as established by

this court. A § 1983 plaintiff is not required to prove criminal intent.

The court in *Gomez v. Toledo*, 446 U. S. 635 (1980), recently addressed the scope of the good faith immunity defense available in a civil rights action under 42 U. S. C. § 1983 (1976). The court explained that the defense has two prongs:

> the applicable test focuses not only on whether the official has an objectively reasonable basis for that belief, but also on whether "[t]he official himself is acting sincerely and with a belief that he is doing right." *Wood v. Strickland*, *supra*, 420 U. S. at 321.

Id. at 641; *accord*, *Scheuer v. Rhodes*, 416 U. S. 232, 247-48 (1974).[6]

This established rationale is also clearly expressed in *Wood v. Strickland*, 420 U. S. 308 (1975):

> However worded, the immunity must be such that . . . officials understand that action taken in good-faith fulfillment of their responsibilities and *within the*

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6 Accordingly, the immunity is available for discretionary, not ministerial, acts. *Harlow v. Fitzgerald*, — U. S. —, 102 S. Ct. 2727, 2738 (1982). The reason is that:

> [i]n contrast with the thought processes accompanying "ministerial" tasks, the judgments surrounding discretionary action almost inevitably are influenced by the decisionmaker's experiences, values and emotions.

"An officer exercising ministerial functions is one whose duties are fairly specifically prescribed and whose decisions may be inhibited by the threat of civil suit without impairing the public interest in effective governmental operations." Sowle, "Qualified Immunity In Section 1983 Cases: The Unresolved Issue Of The Conditions For Its Use And The Burden Of Persuasion." 55 Tulane Law Review 326 (1981).

> *bounds of reason under all the circumstances* will not be punished and that they need not exercise their discretion with undue timidity.

Id. at 321 (emphasis added).

The immunity defense must thus be viewed in its properly limited context. It exists to avoid deterring public officials from freely exercising their judgment where there is some reasonable room for discretion and some legitimate doubt concerning what is supposed to be done. But, in this case, *no one did anything*; thus, none of the respondents exercised any discretion. It only requires common sense to realize that one must *act* to exercise discretion—there is no discretion to do nothing! If respondents had *ever* evaluated Stuebig, as required by the court order, and decided he was still unfit to stand trial, that would have constituted an exercise of discretion. But no evaluation was ever made, therefore, no discretion was ever exercised, and therefore respondents are not entitled to the protection of the qualified immunity defense.

Furthermore, the immunity is subservient to the remedial purpose of § 1983. The good faith immunity defense, which must be *pleaded* and *proved* by defendants, *e.g., Gomez v. Toledo, supra; Skehan v. Board of Trustees,* 438 F. 2d 53, 61-62 (3rd Cir. 1976), cannot so burden the plaintiff's § 1983 claim that it injects into that claim a state of mind requirement. As held by the Supreme Court in *Parratt v. Taylor, supra,* § 1983, unlike its criminal counterpart, 18 U. S. C. § 242, has never been found by this court to contain a state of mind requirement." *Id.* at 1912; *accord, Monroe v. Pape,* 365 U. S. 167, 180, 187 (1961); *Hirst v. Gertzen,* 676 F. 2d 1252, 1263 (9th Cir.

1982) (negligence alone will support a cause of action under § 1983 for deprivation of life).

The court's conclusion further misconstrues the language in *Reese v. Nelson*, 598 F. 2d 822 (3d Cir. 1979), as a statement of the test for good faith immunity, which together with other language, merely characterized the facts in that case as they bore only on the subjective prong of the good faith defense. Such an absolute condition for recovery in this § 1983 action is inconsistent with the history and remedial purpose of section 1983 and is contrary to the test established in *Wood v. Strickland*, 420 U. S. 308 (1975) and repeated in *Gomez v. Toledo*, 446 U. S. 636 (1980).[7]

As held in *Hirst v. Gertzen*, 676 F. 2d 1252 (9th Cir. 1982), in accordance with this Court's decision in *Parratt*, *supra*, even a mere negligent deprivation of life or liberty under color of state law states a claim under § 1983. In the present case, respondents Shovlin, Willis, and Fitzgerald, knowingly permitted injury to Stuebig and others by failing to perform their duties to review and treat.

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7 The District Court's reliance on *Neal v. Secretary of the Navy*, 639 F. 2d 1029 (3d Cir. 1981), further reveals the gravity of its error. Based upon that case, the District Court held that: "[a] court should assume that official discretion has been exercised soundly absent proof to the contrary." Here, however, defendants had no discretion under law to deprive the plaintiff of his right to liberty. Of even more direct importance, *Neal* was a case expressly applicable only to administrative review under an arbitrary and capricious standard not germane to the present civil rights case. The district court's reliance upon *Neal* underscores its error in overburdening the petitioner with unwarranted elements of proof and ignoring the necessary implications of its own findings of defendants' knowing disregard.

This is far more serious than the negligence discussed in *Parratt* and *Hirst*, and presents a conscious state of mind directly inimical to the protection of the most cherished rights guaranteed by the due process clause. Liability must not now be forfeited on the ground that respondents, who disregarded an array of contrary standards and directives, and knowingly allowed grevious harm to occur somehow lacked "malice." The district court's conclusions are utterly contrary to the operative facts which it found, are clearly erroneous, and are contrary to the law as established by this Court.

CONCLUSION

Petitioner Laurence Stuebig's constitutional rights under the Fourteenth Amendment to life and liberty and due process as well as his Fifth, Sixth and Eighth Amendment rights to a fair trial and just punishment, were clearly violated by the actions and non-actions of the respondents. The district court and the Court of Appeals for the Third Circuit failed completely to recognize that respondents had more than sufficient notice of their duty to review and treat petitioner Stuebig during the 35 years he was at Farview. The Court Order committing Stuebig, as well as the state mental health statutes gave respondents abundant notice of their duties. In spite of that, they failed to act, thereby imposing a life sentence on Stuebig for a crime for which he had never been tried.

In addition, the courts below agreed with the respondents' argument that they were entitled to assert the qualified immunity defense because their actions were "dis-

cretionary." In fact, respondents did nothing; respondents failed to act at all; and thus respondents exercised no discretion.

Further, the decisions of this Court make it clear that if the qualified immunity defense is asserted by defendants, a § 1983 plaintiff should not and may not be required to prove malicious intention to cause injury nor required to rebut an asserted presumption of good faith.

WHEREFORE, petitioner Laurence Stuebig, by his guardian, Marie Carole Heckmann, respectfully urges this court to grant his Petition for Certiorari.

Respectfully submitted,

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APPENDIX

Laurence STUEBIG, a/k/a Lawrence Stuebig, by his guardian Maria Carole Heckmann

v.

Robert J. HAMMEL, John P. Shovlin, M.D., Bernard J. Willia, (sic) M.D., John M. Fitzgerald, and Francis Truman.

No. 76-1165 Civil.

United States District Court, M. D. Pennsylvania.

Oct. 19, 1977.

MEMORANDUM AND ORDER

NEALON, Chief Judge.

Presently before the Court is plaintiff's second amended complaint and defendants' motion to dismiss under Rule 12 of the Federal Rules of Civil Procedure. Supporting and opposing briefs have been filed, incorporating by reference supplemental briefs filed earlier in response to the Court's memorandum and order of

March 31, 1977.[1] Jurisdiction is asserted under 42 U.S.C. § 1983, and therefore, under 28 U.S.C. § 1343. Plaintiff alleges that he was involuntarily committed in 1941 to Farview State Hospital for the Criminally Insane following his arrest on charges that he had burglarized a railroad car and received stolen goods.[2] He contends (1) that subsequent to his commitment he was not mentally ill and not a danger to himself or others and that, therefore, defendants had the duty to so inform the court that committed him; or (2), in the alternative, that he was mentally ill and entitled to treatment for his mental illness. Defendants have moved to dismiss on the grounds (1) that the amended complaint fails to state a claim upon which relief can be granted; and (2) that the state statute of limitations applicable in this § 1983 action precludes plaintiff from introducing proof as to events which occurred more than two years prior to the filing of this action.[3] Construing the allegations of the com-

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[1]The Court directed the filing of supplemental briefs addressing the question of whether there exists a generalized right to treatment for mental patients confined in state institutions. Research discloses that the Court of Appeals for Third Circuit has not decided this question. *See also Scott v. Plante*, 532 F. 2d 939, 947 (3d Cir. 1976); *Eubanks v. Clarke*, 434 F. Supp. 1022 (E. D. Pa. 1977).

[2]Plaintiff also alleges that, on December 17, 1975, he was transferred from Farview by order of the Philadelphia County Court of Common Pleas. Defendants state that on that day plaintiff was also committed to Philadelphia State Hospital under 50 Purdon's Pa. Sta. Ann. § 4406 (1969). See Defendants' Brief in Support of the Motion to Dismiss at 3 (Doc. #35, filed June 24, 1977). This provision of the Pennsylvania statutes was subsequently declared unconstitutional in *Goldy v. Beal*, 429 F. Supp. 640 (M. D. Pa. 1976) (three-judge court).

[3]Defendant argued as well that the Court should abstain from deciding this claim under the doctrine of *Railroad Comm'n of Texas v. Pullman Co.*, 312 U. S. 496, 61 S. Ct. 643, 85 L. Ed.

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plaint in a manner most favorable to plaintiff, I hold that he has stated claims upon which relief may be granted. I also hold that, since plaintiff's claims are of a continuing injury, his causes of action accrued on December 17, 1975, and that the filing of this action within the two-year period of limitations on September 6, 1976 permits proof of events occurring between 1941 and 1975.

Adequacy of Plaintiff's Two Claims for Relief

[1] Plaintiff alleges first that subsequent to plaintiff's commitment to Farview defendants knew or should have known that plaintiff was not mentally ill and not dangerous to himself or others. Further, it is alleged that defendants were under a duty and obligation to so inform the committing court and that they arbitrarily and capriciously failed to do so. The constitutional right at issue here is the right to remain at liberty in the absence of a constitutionally adequate basis for confinement. *See O'Connor v. Donaldson*, 422 U. S. 563, 574-75, 95 S. Ct. 2486, 45 L.Ed.2d 396 (1975). It is not alleged that defendants themselves had the authority to release plaintiff from Farview.[4] Defendants contend, not that the exist-

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971 (1941). This contention is without merit. *See Conover v. Montemuro*, 477 F. 2d 1073, 1079-80 (3d Cir. 1973). There is no indication that the state courts are about to give an authoritative decision on state statutes that have been effectively repealed. *See* note 6 *infra*.

Defendants raised other grounds in their motion, but did not brief these issues and apparently only wish to preserve these matters for appeal. *See* Defendants' Brief in Support of the Motion to Dismiss at 25 (Doc. #35, filed Jan. 24, 1977).

[4]Defendants in this action are the current Acting Administrator at Farview, the former Administrator, the Assistant Superintendent and Clinical Director, the Director of Social Services, and the Captain of the Guards.

ence of such a duty would nevertheless fail to state a constitutional claim but rather, that there exists no duty. The purpose of a motion under Rule 12(b)(6) is, however, merely to test the sufficiency of the complaint; as stated in this Court's memorandum and order of March 31, 1977:

> "An allegation that employees of a mental institution violated an inmate's rights by not releasing him when they discovered that he was no longer mentally ill states a cause of action . . . only when the complaint also alleges that the employees had . . . the duty to inform the court of his improved condition and that their failure to take such action was arbitrary and capricious."

The second amended complaint contains these allegations, and, therefore, plaintiff has stated a claim. *See* authorities cited in March 31, 1977 memorandum at 3.

(2) Moreover, treating the question of the existence of the alleged duty as a question of law determinative of whether plaintiff has stated a claim, I find that there did exist a duty to inform a committing court of a patient's subsequent lack of mental illness. Defendants contend that there existed no duty on their part to advise a committing court that a patient had regained his sanity, and cite Pennsylvania statutes which impose the duty to seek release either on the patient or on the Department of Public Welfare.[5] Plaintiff in response cites other statutes, including 50 Purdon's Pennsylvania States Annotated § 4409(b) (1969), which provides that where there is a person who has been committed on pending criminal charges (as was plaintiff) and who

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[5]The Department and its Secretary are not parties to this action.

> "shows a sufficient improvement of condition so that his continued commitment is no longer necessary, he shall be returned to the court having jurisdiction of him for trial or such other disposition of such charges as the court may make."[6]

See also 50 Purdon's Pa. Stat. Ann. § 4408(e) (1969). I am satisfied that in terms of the applicable state law, while most court cases would be concerned with instances where a patient sought release, *see, e.g., Skipper v. Shovlin*, 368 F. 2d 954 (3d Cir. 1966), there also existed a duty on the part of person or persons within a mental institution to request review by a committing court of a person who had regained his sanity. Moreover, the question of whether the duty has existed is not wholly dependent upon state law: State officials charged with the administration of mental hospitals are clearly bound by federal constitutional law as well. As the Supreme Court has recently stated,

> "That a wholly sane and innocent person has a constitutional right not to be physically confined by the State when his freedom will pose a danger neither to himself nor to others cannot seriously be doubted."

O'Connor v. Donaldson, 422 U. S. 563, 573 n. 8, 95 S. Ct. 2486, 2492, 45 L. Ed. 2d 396 (1975). Plaintiff's first claim for relief states no more than this—that he was no longer

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[6]It is not a matter of record as to whether this statute, approved in 1966 and repealed in 1976, had a counterpart in the Mental Health Act of 1951 and the Mental Health and Mental Retardation Act of 1923. The Mental Health Procedures Act of 1976, 50 Purdon's Pa. Stat. Ann. § 7101 *et seq.* (Supp. 1977), now provides, to the mentally ill, many of same rights claimed herein as a matter of constitutional law. *See generally* Note, *Pennsylvania's New Mental Health Procedures Act: Due Process and the Right to Treatment for the Mentally Ill*, 81 Dick L. Rev. 627 (1977).

mentally ill and that other persons charged with his care and custody made no attempt to secure his release. *Cf. id.* at 574-75, 95 S. Ct. 2486. This is a claim upon which relief can be granted.[7]

In the alternative, plaintiff alleges that he was mentally ill during his confinement at Farview and that he was not provided with treatment. Plaintiff contends that a person in his circumstances enjoys a constitutional "right to treatment." Defendants argue that the complaint is fatally defective as to his claim because plaintiff could also be confined as a danger to himself and others and that confinement for that reason would not require that plaintiff be treated.[8] However, a reading of the second amended complaint in a manner most favorable to plaintiff indicates that he is alleging that his confinement was not on account of dangerousness to himself or others but rather for treatment. While plaintiff asserts alternately that he was and was not mentally ill, plaintiff never varies from the allegation that he "was not dangerous to himself or others." In the alternate claim plaintiff alleges that "knowing that he was mentally ill, [defendants] were under a duty and obligation to render him

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[7]It must be stressed that this holding is far short of a pronouncement that plaintiff has proved the lack of mental illness, and the existence of a duty on the part of each defendant. Indeed, it is not predetermined that, in a motion for summary judgment, plaintiff can establish the existence of a material issue of fact as to these matters. In addition, defendants are not foreclosed from arguing defense of good faith based upon the state statutes defendants have cited.

[8]In *O'Connor v. Donaldson*, 422 U. S. 563, 95 S. Ct. 2486, 45 L. Ed. 2d 396 (1975), the Court expressly reserved the question of whether treatment need be provided to one who is involuntarily confined because of dangerousness. *See id.* at 570 n. 6, 95 S. Ct. 2486.

medical treatment . . . ." This duty and obligation could arise, for example, when involuntary commitment has been ordered for treatment purposes, and the complaint will be so construed.[9]

[3, 4] Thus, the issue before the Court as to this alternate claim is whether a person who is confined in order to be treated and who is mentally ill although not dangerous to himself or others has a right to receive the treatment that is the basis for the confinement.[10] In these more narrow circumstances, it is clear that a "right to treatment" does exist, but only as a matter of due process, and not as an independent constitutional right:

> "Where 'treatment' is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground [treatment] is present."

Donaldson, 422 U. S. at 574, 95 S. Ct. at 2493 (dicta), *citing Jackson v. Indiana,* 406 U. S. 715, 92 S. Ct. 1845, 32 L. Ed. 2d 435 (1972). *See Developments in the Law—Civil Com-*

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[9]Plaintiff has argued in his brief that the 1941 commitment was ordered for the purposes of treatment. *See* Plaintiff's Supplemental Brief at 5-6 & 8 (Doc. #17, filed May 4, 1977). Thus, it will work no unfairness on plaintiff to so construe the complaint. It could have been contended that a duty and obligation to provide treatment also arises in cases where the commitment was not for purposes of treatment. Such a construction of the complaint would have necessitated that the Court face the more difficult question of whether a generalized right to treatment exists.

[10]Plaintiff is not claiming that he should have been released because his mental illness did not involve dangerousness. That mental illness alone may not justify custody is the holding of the Supreme Court in *Donaldson,* however, and the only claim actually reached in that case.

mitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1324-29 (1974). *See also Wyatt v. Aderholt*, 503 F. 2d 1305, 1312-14 (5th Cir. 1974);[11] *Stachulak v. Coughlin*, 364 F. Supp. 686 (N. D. Ill. 1973); *Eubanks v. Clarke*, 434 F. Supp. 1022 (E. D. Pa. 1977). *Cf. Martarella v. Kelley*, 349 F. Supp. 575, 598-602 (S. D. N. Y. 1972). *Contra, Burnham v. Department of Public Health of Georgia*, 349 F. Supp. 1335 (N. D. Ga. 1972). Thus, plaintiff has stated an alternate claim for relief upon which relief can also be granted.[12]

Limitations Period Applicable to Plaintiff's Claim

[5] Plaintiff was committed in 1941 and remained at Farview until December 17, 1975. As a result of the claimed deprivations suffered during this period, plaintiff seeks damages from defendants. The complaint was filed on September 9, 1976. The parties agree that the two-year limitations period borrowed from state law, *see* 12

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[11]Although this decision depended in part upon a case subsequently vacated by the Supreme Court on other grounds, *see Donaldson v. O'Connor*, 493 F. 2d 507 (5th Cir. 1974), *vacated and remanded*, 422 U. S. 563, 95 S. Ct. 2486, 45 L. Ed. 2d 396 (1975), the essential reasoning in *Wyatt* is unaffected by that action.

[12]Again, it must be stressed that I have only decided that plaintiff has stated a claim. *See* note 7 *supra*.

Defendant renews his contention that the complaint fails to state sufficient facts in support of its conclusions and allegations. *See generally Negrich v. Hohn*, 379 F. 2d 213 (3d Cir. 1967). Further factual specificity in the complaint would provide defendants with more detail of plaintiff's case but would not further the basic principle of notice pleading. It would be inappropriate here to require such specificity when such matters are more properly a concern during discovery. *See Eubanks v. Clarke*, 434 F. Supp. 1022 (E. D. Pa. 1977).

Purdon's Pa. Stat. Ann. § 34 (1953), governs this action. *See Polite v. Diehl,* 507 F. 2d 119, 122 (3d Cir. 1974). Defendant argues that plaintiff may not prove damages for anything occurring prior to September 9, 1974, two years prior to the filing of this action, since two years is the governing limitations period and since there are no circumstances which would toll the statute. There are two fallacies in defendants' argument: First, the limitations period applies to *claims* and not supporting evidence; secondly, the question is not as defendants would have it whether the action was tolled but rather the issue is when the action accrued.

[6] The allegations are of a continuing wrong ending when plaintiff was transferred from Farview in 1975. The law of Pennsylvania, applied in this case in accordance with *Polite,* provides that a cause of action for a continuing injury accrues only when the wrong terminates. *See* 22 Pennsylvania Law Encyclopedia § 64 (1959). *Cf. Donaldson v. O'Connor,* 493 F. 2d 507, 529 (5th Cir. 1974), *vacated on other grounds,* 422 U. S. 563, 95 S. Ct. 2486, 45 L. Ed. 2d 396 (1975); *Fowkes v. Pennsylvania R. R. Co.,* 264 F. 2d 397 (3d Cir. 1959). Since the allegations of the complaint must be taken as true, it does not appear that the continuing injury plaintiff alleges ended before September 6, 1974. Thus, plaintiff's claims are not barred by the applicable limitations period.

The motion to dismiss will be denied. Defendants have ten days within which to file their answer. *See* Fed. R. Civ. P. 12(a)(1).

CIVIL NO. 76-1165

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

LAURENCE STUEBIG,
a/k/a LAWRENCE STUEBIG,
by his guardian MARIA
CAROLE HECKMANN,

Plaintiff

v.

ROBERT J. HAMMEL, et al.,

Defendants

MEMORANDUM AND ORDER

(Filed December 31, 1981)

Laurence Stuebig, brought this action under 42 U. S. C. § 1983 (1976), seeking damages from certain employees at the Farview State Hospital for the Criminally Insane. Plaintiff spent nearly thirty-five years incarcerated at that facility following his involuntary commitment in 1941. He contends that the defendants violated his civil rights by neither releasing nor treating him during his stay at Farview. This action was tried by the court between February 26 through 29 of 1980. Since that time, the parties have filed requests for findings of fact, proposed conclusions of law and briefs. Additionally, the parties have addressed this Circuit's recent discussion of the treatment of the involuntarily committed. *See Romeo v.*

Youngberg, 644 F. 2d 142 (3d Cir.) (*en banc*), *cert. granted*, 101 S. Ct. 2313 (1981).

Although the pendency of the *Youngberg* case before the United States Supreme Court leaves the question of treatment rights for the mentally ill in an uncertain state, the parties tried and argued this case on the basis of theories that differ sufficiently from *Youngberg* to make present disposition of this action proper. For the reasons that follow, judgment will be entered for all defendants.

FINDINGS OF FACT

I. THE PLAINTIFF

1. On January 15, 1941 the plaintiff Larry Stuebig, then 38 years old, was arrested in a railway yard in Philadelphia. He and a companion were charged with vagrancy and trespassing on railroad property. Subsequently, a charge of breaking and entering a railroad boxcar with intent to steal property valued under $250.00 was added against both defendants. Plaintiff's Exhibit 2, at 18.

2. Plaintiff exhibited odd behavior during his confinement, and a "lunacy commission" was convened to examine him. The commission consisted of two physicians and an attorney. After taking testimony and a statement from the plaintiff, the commission found that plaintiff was insane, that he required care in a mental institution and that plaintiff had criminal tendencies. As a result of these findings, the commission recommended committing plaintiff to "a hospital for mental diseases." Plaintiff's Exhibit 16.

3. The Commission's findings rested entirely on plaintiff's own testimony and the testimony of a prison guard who had observed plaintiff during his confinement. The Commission's conclusion concerning plaintiff's insanity apparently rested on evidence that he suffered from delusions of grandeur. The determination concerning criminal tendencies apparently resulted from the pending burglary charge and a finding that plaintiff was a former inmate of the psychiatric ward in the Pennsylvania State Hospital. *Id.*

4. Acting on the Commission's report, the Quarter Sessions Court of Philadelphia County committed plaintiff to Farview State Hospital by an Order dated February 6, 1941. The Order provided that plaintiff "be there detained and treated as an insane person at the expense of the County of Philadelphia until further order of the Court. . . ." *Id.* This procedure was authorized by Act of July 11, 1923, Art. III, § 308, P. L. 998 (formally codified at 50 P. S. § 48 (1936)). Plaintiff's actual admission to Farview took place on February 15, 1941. Plaintiff's Exhibit 16.

5. When the Philadelphia Quarter Sessions committed plaintiff to Farview, he was suffering from mental illness. His disorder was a form of schizophrenia. This mental disorder manifested itself chiefly in delusions of grandeur. Plaintiff's symptoms for example, included the false belief that he had great wealth. 2 trial transcript, at 15, 29-30, 39-40, 52, 217, 219.

6. Schizophrenia is a diagnostic label attached to a syndrome, or group of symptoms. The symptoms, in common parlance, could be described as "thought dis-

orders." Subjectively, a schizophrenic experiences hallucinations, which are perceptions lacking a basis in reality, and delusions, which are persistent false beliefs entirely unsupported by fact. Schizophrenics often exhibit "inappropriate affect," which is emotional behavior grossly unsuited to the occasion. Dr. Melvin Heller, who testified for the defendants as an expert, cited a patient smiling while saying "my Mother died" as an example of inappropriate affect. 2 trial transcript, at 19-20, 61; 4 trial transcript, at 7-8.

7. Plaintiff could not be described as a classics (sic) schizophrenic. Farview records indicate that he did not suffer from some of the symptoms associated with schizophrenia. Plaintiff did not "act out" violently and thus presented no danger to the physical well being of others. Furthermore, the ward notes suggest that plaintiff only experienced auditory hallucinations intermittently. "Real" hallucinations were apparently absent, and whatever auditory hallucinations plaintiff experienced did not prevent him from performing work on the ward. 2 trial transcript, at 27, 30, 39-40; Plaintiff's Exhibit 2, at 7-14.

8. Psychiatrists often classify mental illness both according to the persistence of its symptoms and the degree of impairment that the illness inflicts. Generally, the persistence of the symptoms may be described as acute or chronic. Sudden onset and short duration characterize acute mental illness; symptoms of long duration characterize chronic mental illness. The degree of impairment, on the other hand, may be measured on a scale of mild to severe. Psychiatrists would describe plaintiff's illness as a mild to moderate case of chronic schizophrenia. 2 trial transcript, at 39-40; 50-52; 3 trial transcript, at 8-9, 98-99.

9. During the course of his stay at Farview, plaintiff's mental condition deteriorated largely because of two developments unrelated to his schizophrenia. First, plaintiff progressively developed organic brain syndrome. This organic deterioration of the brain, also called Alzheimers disease, can cause forgetfulness, disorientation or even delusions. Senility is the most commonly recognized form of organic brain syndrome. The ward notes indicate that organic brain syndrome may have begun to manifest itself as early as 1960. The second factor contributing to plaintiff's deterioration was chronic institutionalization. Because institutionalization deprived plaintiff of the normal type of stimuli that human beings ordinarily experience, plaintiff began to lose both mental acuity and his sense of orientation. 2 trial transcript, at 40-41, 44-46; 4 trial transcript, at 79-80; Plaintiff's Exhibit 2 at 11a.

10. Presently, plaintiff is unable to care for himself. He is in the terminal stages of untreated schizophrenia; he has "burned out" or wasted away. Although organic brain syndrome has, to a minor extent, contributed to the plaintiff's present condition, his condition is primarily attributable to lack of treatment for the schizophrenia and the effects of chronic institutionalization. During most of his stay at Farview, he represented no danger to himself. 2 trial transcript, at 22-25, 45-46, 217.

11. Plaintiff remained at Farview until December 15, 1975. The Court of Common Pleas of Philadelphia ordered plaintiff released to Philadelphia State Hospital on December 17, 1975, and, at the same time, the District Attorney entered a nollo prosequi on the outstanding criminal indictment because the statute of limitations had

run on the charge. Plaintiff was ultimately admitted to Pennsylvania State Hospital on December 19, 1975 where he remained until May 20, 1978. Plaintiff's Exhibit 2, at 2; Plaintiff's Exhibit 16; 1 trial transcript, at 28.

12. During March of 1976, Maria Carole Heckmann became the guardian of Laurence Stuebig. She instituted the present action on September 9, 1976 alleging that plaintiff's incarceration had violated his civil rights. Following several amendments, the plaintiff named fourteen defendants, all employees or former employees at Farview. During trial, plaintiff dismissed eight defendants from the case. Those dismissed defendants were Robert J. Hammel, Charles A. Zeller, M.D., Harry D. Probst, M.D., Vincent P. Covoleski, D.S.C., G. J. Salko, M.D., Herbert L. Owens, M.D., Doctor Paul Ferraro and J. Paul Hearst, M.D. Six defendants now remain. 2 trial transcript, at 86; 3 trial transcript, at 151.

II. THE DEFENDANTS

13. Defendant Bernard J. Willis was a member of the Farview staff from June 1, 1955 until his retirement in 1977. Dr. Willis began as a member of the general medical staff, but after one or two years of working in the hospital infirmary, Dr. Willis began to assume responsibility for conducting the staff evaluation program at Farview. During the next five years, Dr. Willis assumed responsibilities as an acting clinical director. This transition from head of staff evaluations to clinical director occurred during the late 1950's. Until his retirement, Dr. Willis continue was clinical director. 3 trial transcript, at 45, 58-60, 90.

14. Although Dr. Willis held the position of clinical director from the late 1950's until 1977, he had never received formal psychiatric training beyond any training incident to his medical education. Dr. Willis had, however, attended psychiatric seminars. Moreover, Dr. Willis had acquired an extensive understanding of psychiatric problems, primarily through self education. Dr. Melvin Heller, defendant's expert psychiatric witness, described Dr. Willis as "a kind of Grandma Moses of psychiatry." Other courts have acknowledged Dr. Willis's psychiatric knowledge by accepting his testimony as an expert witness in the field. 2 trial transcript, at 44, 114; 3 trial transcript at 44-45; 4 trial transcript at 88.

15. Defendant John P. Shovlin, M.D., joined the staff of Farview in 1937 as a ward physician. He worked in that capacity until 1941, when he left Farview for military service. He returned in 1946 and, after a year, became the Assistant Superintendent at Farview. In 1949, Dr. Shovlin became the Superintendent and held that position until he retired in 1974. 4 trial transcript, at 171-72.

16. Dr. Shovlin received board certification as a psychiatrist in 1947. He had studied psychiatry and neurology at the University of Pennsylvania. In addition to his experience at Farview before becoming Superintendent, Dr. Shovlin had psychiatric experience during his military service. He was the Chief of the Neuro-psychiatric sections first at Fort Meade and then at Fort Belvoir hospitals. 4 trial transcript, at 73.

17. Defendant John M. Fitzgerald joined the staff at Farview in August of 1971. He was hired to serve as Director of Social Services. He acted as Farview's Director of Social Services through the time of trial.

18. Mr. Fitzgerald received social work training at the University of Pennsylvania between 1967 and 1968. Before becoming Director of Social Services at Farview, he worked at the state civil mental hospital in Clarks Summit, Pennsylvania. Mr. Fitzgerald arrived at Clarks Summit in 1964 and worked there while obtaining his social work degree. He left the staff at Clarks Summit to take the position at Farview. 3 trial transcript, at 179-80.

19. Defendant Francis Truman joined the staff at Farview as a "guard" in 1954. Mr. Truman was promoted to "guard supervisor" in 1961. He received a second promotion to "Captain of the Guards" in 1974. Mr. Truman remained as Captain until he retired in 1977. 3 trial transcript, at 159-60.

20. Defendant William H. Horan, M.D., became a member of the Farview medical staff in 1967. He worked as a ward physician on "R" and "S" wards. Dr. Horan retired from service at Farview in 1977. 3 trial transcript, at 208-09.

21. R and S wards were designed, respectively, for patients in need of medical treatment, and for patients convalescing from surgical or other medical treatment. Essentially, R and S wards were hospital wards. The institution's infirmary was also operated out of S ward. Because these wards primarily provided medical care and treatment, a ward physician on R or S ward would principally occupy himself with examining and diagnosing patients' medical problems, and prescribing and carrying out treatment for those problems. 3 trial transcript, at 210-12.

22. Dr. Horan is not a trained psychiatrist. He never received specialized training in psychiatry before he arrived at Farview. He had received his medical training at the University of Maryland in the 1930's. His medical background consisted of a year and a half of general medicine, private practice, military service, and some twenty years of practice in internal medicine.

23. Phillip Powell, M.D., joined the staff at Farview in 1969. Originally, Dr. Powell was hired to conduct annual physical examinations of the patients, work sick calls, and man the medical clinic. By 1970, however, Dr. Powell had been shifted to ward physician duties. Dr. Powell remained a ward physician, primarily on "H" ward, until his retirement in 1978. 3 trial transcript, at 3, 18.

24. Dr. Powell had little formal psychiatric training. After graduating from medical school in 1959, Dr. Powell had worked primarily as a general surgeon. In addition, he did a tour of military service. Although Dr. Powell had served for a year in another psychiatric hospital, he acted solely as a surgeon. 3 trial transcript, at 5-6, 13.

III. THE INSTITUTION

25. Farview State Hospital for the Criminally Insane is a state operated, maximum security mental institution for confining and treating the mentally ill offender or defendant. The hospital, which was established in the early decades of the Twentieth Century, is located in Waymart, Pennsylvania. The facility contains approximately fourteen wards holding up to 1,400 patients. 2 trial transcript, at 123; 4 trial transcript, at 48-49.

26. Patients arrive at Farview by one of several routes. Many are referred to the institution from the criminal justice system. This group would include court commitments resulting from the finding of incompetence to stand trial, and court commitments following verdicts of not guilty by reason of insanity. Other patients are transferred there from the state correctional system. Still other patients, who could not be controlled in other civil institutions because, for example, they exhibited a pattern of assaultive behavior, were removed to Farview. 4 trial transcript, at 48-49.

27. Commitment to Farview did not necessarily result from a clinical evaluation that a patient required housing in a maximum security institution. Original commitments from a court usually reflected either a patient's history of criminal conduct, or the pendency of a criminal charge. 4 trial transcript, at 51.

28. In the late 1930's and early 1940's, about 800 patients were institutionalized at Farview. There was a staff of about 400 to provide care and treatment. Only a small portion of the staff, moreover, was trained to provide medical or psychiatric care. The guard population made up the bulk of the staff. Aside from the Superintendent, there were five physicians. None of the physicians, however, was board certified in psychiatry. At that time, Farview employed no nurses, psychologists, or social workers. 4 trial transcript, at 174.

29. By the mid 1940's, the patient population had grown to approximately 1,000. The Superintendent, Thomas Rutherford, M.D., was the only board certified psychiatrist, although Dr. Shovlin, who had rejoined the

staff in 1946, was considered a trained psychiatrist. The rest of the medical and professional staff consisted of three physicians and a nurse. 4 trial transcript, at 174-175.

30. Both the patient population and the staff had grown by 1950. There were about 1,100 patients and about 525 staff members. None of this growth had increased the size of the medical staff. There was still no social service staff. 4 trial transcript, at 175-176.

31. By 1955, there were about 1,200 patients at Farview. The staff, by then, numbered about 530. The medical and professional staff had grown only slightly. Dr. Shovlin had become Superintendent, and Dr. Willis had begun to assume staff evaluation duties. In addition, there were approximately three physicians, two psychologists and a few nurses. 3 trial transcript, at 117-18.

32. In the early 1960's, the patient population continued to grow. There were 1,410 patients, the peak population, in 1964. The medical and professional staff made up a small portion of the entire staff, which still numbered around 530. Dr. Shovlin was the only board certified psychiatrist, although Dr. Willis had acquired considerable psychiatric experience. There were between three and five other physicians. Two psychologists, one social worker, and two or three nurses rounded out the medical and professional staff. 3 trial transcript, at 119-20.

33. By the time the patient population had reached its peak at 1,410 in 1964, the medical and professional staff had increased slightly. In addition to Drs. Shovlin and Willis, there were four physicians, four psychologists, two

or three social workers and three nurses. The staff as a whole numbered 550. 4 trial transcript, at 120.

34. The 1970's were characterized by a decrease in patient population and an increase in staff size. There were about 900 patients in 1970 which was reduced to approximately 600 in 1974. Other than the Superintendent and clinical director, there were between five and seven physicians. One to three additional psychologists joined the staff raising the total to between five and eight, and the nursing staff had quadrupled to about a dozen by 1970. By 1974 the nursing staff had swelled to about 36. 3 trial transcript, at 120-21.

IV. AVAILABLE TREATMENT FOR SCHIZOPHENIA

35. At the time that plaintiff was admitted to Farview, few therapy modalities existed for treating schizophrenics. In addition to psychotherapies, psychiatrists had available the techniques of electric shock therapy, chemical shock therapy, hydrotherapy and occupational or recreational therapy. None of these therapy modalities held great promise for the treatment of schizophrenics. 2 trial transcript, at 183-84; 4 trial transcript, at 13-16.

36. Psychotherapies or verbal therapies are intuitive therapies in which the therapist talks with the patient. Psychoanalysis is one form of verbal therapy. This type of therapy is largely unsuccessful when applied to schizophrenics because therapists are usually unable to dissuade schizophrenics from delusional ideas. Attempts to persuade paranoic schizophrenics may only reinforce paranoid ideas. 4 trial transcript, at 11-13.

37. Another treatment modality was electroconvulsive therapy or electroshock therapy. Although many psychiatrists use electroshock therapy in most cases, the majority of clinicians believe that electroshock therapy was not indicated for the treatment of schizophrenia. Psychiatrists were unlikely to use electroshock therapy unless a particular schizophrenic proved intractable or difficult. Moreover, a very respectable minority of psychiatrists would oppose use of electroshock therapy for any psychiatric disorders. 2 trial transcript, at 10-11; 4 trial transcript, at 13-14.

38. Chemical shock therapies offered another treatment modality. Insulin shock therapy was one such technique. The psychiatrist would give a patient large doses of insulin which would lower the patient's blood sugar until the patient went into shock. After the patient had remained in shock for some time, the psychiatrist would inject sugar, which would return the patient to a normal state. Since the therapy rendered the patient unconscious for long periods, patients undergoing insulin shock therapy required the constant attendance of medical personnel. Other chemical shock therapies were similar. 4 trial transcript, at 14-15.

39. Hydrotherapy or "somatic" therapies offered another treatment alternative. Patients would receive baths, either hot or cold, or patients would be exposed to high velocity water hoses. This therapy was primarily used on hyperanxious or excited patients. 2 trial transcript, at 184; 4 trial transcript, at 186.

40. Other therapies centered around exercise or activity programs. These included occupational therapy and recreational therapy. This form of treatment sought to

involve patients in real world activities, which could include supervised relationships with other patients. Activity programs also helped to prevent patients from becoming vegetative and avoided permitting the patient to dwell on his emotions. 2 trial transcript, 12, 184; 4 trial transcript, at 185.

41. During Plaintiff's stay at Farview, another more effective therapy for schizophrenia was introduced. Beginning in the middle 1950's, "psychoactive" or "antipsychotic" drugs became available. These drugs, thorazine, known generically as chlorpromazine, and its derivatives, have potent antipsychotic effects. Thorazine and derivative drugs often reduced or terminated psychotic symptoms in schizophrenics. 2 trial transcript, at 13, 15; 4 trial transcript, at 17-18.

42. The antipsychotic drugs, related to thorazine, often offered an effective treatment for schizophrenia. Largely as a result of the introduction of these drugs, patient population in mental hospitals throughout the country declined. The drugs provided a means of treating psychoses, and, in turn, facilities could utilize staff that had previously been occupied by duties such as guarding patients to more productive therapeutic activities. 2 trial transcript, at 13, 210-11.

43. Antipsychotic drugs, however, frequently had adverse side effects. These side effects could, in their most common form, produce "atropenic effects," which varied from dryness of the mouth to blurring of the vision. A more extreme side effect would be a drug-induced condition similar to Parkinson's Disease. A patient afflicted with such a side effect might exhibit muscular rigidity,

tremors, drooling, or stiffness of movement. Thorazine-related drugs could induce heart problems, cause liver damage or irreversible neurological damage in some patients. In older patients, Dr. Heller testified that the drugs could induce "adrenergic blocking effect" which could cause falls with the resulting possibility of bone breakage. 2 trial transcript, at 57-60; 4 trial transcript, at 17-20.

44. Although all psychoactive drugs had the capacity to produce side effects, not every patient would experience side effects. The most common side effect would be dryness of the mouth. The other more serious side effects were rare. Dispensing physicians often controlled side effects by administering low dosages and slowly increasing the dosage. If side effects manifested themselves, a lower dosage would be prescribed. Once results were achieved with the medication, a low maintenance dosage would be used. 2 trial transcript, at 59-60; 3 trial transcript, at 76-77.

45. Treatments of schizophrenics through the use of antipsychotic drugs had advantages over previous therapy modalities. A psychiatrist did not have to attend on the case in order to prescribe such a drug. A general physician could prescribe psychoactive drugs easily. Although patients would need observation to guard against the possibility of side effects, a nurse or lay person could identify side effects and bring them to the attention of the prescribing physician. If controlled by laboratory examination, daily rounds would suffice as a monitoring method. 2 trial transcript, at 59-60; 3 trial transcript, at 83; 4 trial transcript, at 23.

V. TREATMENT PROGRAM AT FARVIEW

46. The Superintendent of Farview has responsibility for administering the overall operation of the facility. Virtually all of the Superintendent's time is absorbed by these duties; direct clinical duties do not constitute any significant part of the Superintendent's job. Rather, the Superintendent delegated most clinical duties to the clinical director.

Much of the Superintendent's time was occupied by planning the institution's budget, overseeing food preparation, supervising maintenance of the hospital and investigating complaints against staff members. The Superintendent's responsibility for care and treatment of patients was supervisory. This portion of the Superintendent's administrative duties entailed formulating institutional policy in conjunction with the Pennsylvania Department of Public Welfare, establishing standards to resolve problems of patient welfare, reviewing reports from staff evaluations concerning patients and approving discharges from the institution. As part of this duty of supervising the providing of care and treatment, the Superintendent conferred with his staff to ascertain whether they were executing their duties properly. 2 trial transcript, at 226; 4 trial transcript, at 176-80, 219.

47. The clinical director at Farview had general responsibility for directing and coordinating clinical programs. As part of this responsibility, the clinical director oversaw both the medical and psychiatric treatment for the patient population at Farview. This included management of staff evaluations, a duty that Dr. Willis had previously assumed before becoming clinical director. Staff

evaluations consisted of conferences for evaluating improvement in a patient's condition preparatory to his release. The clinical director also bore responsibility for protecting patients' civil rights. The clinical director carried out these responsibilities chiefly by delegating clinical duties to other staff members. In addition, the clinical director at Farview carried a direct patient load. 2 trial transcript, at 123, 225-29; 3 trial transcript, at 56, 96-100.

48. Ward physicians at Farview were immediately responsible for treating patients, safeguarding patients, and obtaining recovery or cure. A ward physician was expected to provide both medical and psychiatric care. Up to 40 percent of a ward physician's daily duties were psychiatric in nature. 3 trial transcript, at 76; 4 trial transcript, at 252.

49. The Director of Social Services at Farview oversees the activities of the staff social workers. These social workers were expected to deliver a variety of social services, including admitting patients, helping patients adjust to the emotional problems of institutionalization, obtaining social history backgrounds of the patients for staff evaluation, and helping patients to maintain family contact. The Social Services Department also dealt with patient-related legal problems. This included checking the status of patients' commitments and ascertaining what reports were due to committing courts.

50. The duties of a guard, also referred to as a "psychiatric security aide", included directing day to day activities in the wards at Farview. Occasionally, guards were expected to administer drugs to patients under doc-

tor's orders. Guards could also initiate inquiries into a patient's treatment status by bringing information about improvement in a patient's condition to the medical staff's attention. Guards also had responsibility for controlling patients. If a patient's behavior endangered the safety of the ward, guards were charged with removing patients from the general population. 3 trial transcript at 104; 3 trial transcript, at 48, 69, 72, 99, 117, 178; 4 trial transcript, at 231. A guard supervisor apparently had responsibility for overseeing the work of the guards and checking on patients who acted as ward workers. 1 trial transcript, at 158-59.

51. Before antipsychotic drugs were introduced in the mid 1950's, the staff of mental hospitals were primarily devoted to guarding the patient population. This was true at Farview also. A transition to more active treatment programs in the mental health field began with advent of antipsychotic drugs. 2 trial transcript, at 211; 4 trial transcript, at 17.

52. Thorazine was perfected in 1952. By 1955, however, only limited quantities of the drug were becoming available at Farview. Widespread use of antipsychotic drugs was hindered by budgetary constraints in the first two years after the drug's introduction. Initially, the manufacturer of the drug made generous amounts of the drug available through donations in 1955 and 1956. Thereafter, the budget of the institution increased sufficiently to make use of the drugs on a broader scale possible. 3 trial transcript, at 61, 64, 124.

53. During the first several years in which the drug was available, the staff at Farview medicated patients se-

lectively. The staff singled out only patients who were in good health and for whom the drug was most likely to be helpful. The clinical director believed that this procedure was necessary because no one at Farview had experience with the drug, proper dosages or the management of potential side effects. 3 trial transcript, at 62-63.

54. Once experimentation on a particular drug ended, the purported policy at Farview was to medicate anyone who showed a promise of response to that medication. Once free use of the medication began, about a third of the patient population at Farview received drug therapy according to Drs. Shovlin and Willis. The Farview policy called for exclusion of only two groups of patients. The staff were directed not to medicate new patients until evaluation and diagnosis were complete. The staff also would not medicate a patient who refused drugs if forced medication would disrupt the ward or if there was little likelihood of successful use of the medication. 3 trial transcript, at 69, 125-126.

55. After a trial period with antipsychotic drugs, the institutional policy at Farview called for aggressive use of drug therapy. The antipyschotic drugs introduced in 1955 underwent only experimental use for about a year and a half. Experiments with various antipsychotic drugs continued at Farview until about 1960. As new types of antipsychotic drugs were put on the market, the policy at Farview called for use of that drug to discover which drugs best produced results. 3 trial transcript at 70, 124-25.

56. Although the Farview medical staff was small, sufficient manpower existed to carry out a drug treatment program. 2 trial transcript, at 201-02.

57. Responsibility for several types of psychiatric care fell on ward physicians. In the course of daily rounds, ward physicians were expected to confer with guards concerning patients' general condition, progress, and response to medication. Ward physicians were also expected to interview, counsel and treat patients. The ward physicians or the clinical director would prescribe medication for psychiatric needs and could also refer patients for staff evaluation. 3 trial transcript, at 61, 216; 4 trial transcript, at 176, 231, 252.

58. Throughout this period, a patient seeking discharge from the institution depended on a favorable recommendation from a staff evaluation and the approval of the Superintendent, unless a court ordered the discharge. A formal staff evaluation consisted of psychological testing, an interview with the patient and general discussion by the medical staff after obtaining input from the entire staff, including guards. 2 trial transcript at 143; 3 trial transcript, at 128.

59. During the tenures of Drs. Shovlin and Willis any staff member could initiate a staff evaluation by submitting a patient's name for initial screening. Even guards were allowed to add a patient's name to the list for screening. All staff members were expected to do so if they noted improvements in a patient's condition. 3 trial transcript, at 96.

60. The only other systematic check for either release or treatment of patients during the tenures of Drs. Shovlin and Willis came in the form of ward notes. Ward physicians were expected to make notes on each patient at least semiannually. The records librarian would keep

track of the patients who were due for evaluation through ward notes. When patients were scheduled for examination, the librarian would give the ward physician a list of these patients. After examining the patient, the ward physician would submit his report for incorporation into the patient's file. 3 trial transcript, at 89-90, 102, 127-28; 4 trial transcript, at 212.

61. In practice, however, this system for providing drug treatment was ineffective. Primary responsibility for identifying patients who would respond to drug treatment was delegated to the medical staff. The ward physician's daily rounds and interviews for ward notes purportedly supplied the opportunity for this evaluation. However, according to Dr. Powell, the daily rounds at Farview served primarily for evaluation of medical problems.

62. Evaluations of ward notes were to be conducted by the ward physician supervising the ward on which the patient resided. The ward physician would interview the patient in the ward office after he had finished his daily rounds. A guard would be present throughout the interview. 3 trial transcript, at 19. Unless ward notes were reviewed by the Medical Office, the system would hardly constitute an effective check on the quality of work being done by ward staff.

63. If daily rounds and semiannual evaluations did not identify a patient as a candidate for treatment or release, no oversight mechanism existed to correct the error. Dr. Shovlin acknowledged that a patient's lack of treatment would never come to his attention unless the clinical director or the ward physician initiated an inquiry. Dr. Shovlin admitted that he never initiated review of patient

charts periodically to determine whether ward physicians were fulfilling patient treatment needs adequately. 4 trial transcript, at 212-13, 231.

64. Instead, Dr. Shovlin testified, he delegated clinical duties to Dr. Willis. Dr. Shovlin would know nothing of patient treatment, but relied upon the clinical director. Dr. Shovlin believed that, as Superintendent, his obligation was to bring other members of his staff together and oversee whether they performed their jobs properly. Finding of Fact 46; 4 trial transcript, at 219.

65. In the period between the late 1950's and early 60's, when a policy of free use of psychoactive drugs was in effect, defendant Willis was in charge of both treatment and the staff evaluation programs. Dr. Willis stated that, in his opinion, ward physicians bore the ultimate responsibility for prescribing treatment. Moreover, Dr. Willis testified that he became involved in patient treatment plans only when he had direct ward responsibility for that patient, or when the patient was referred for staff conference. 3 trial transcript, at 99-102.

66. The staff conference system offered no effective access to diagnosis or treatment for a patient who was overlooked by the ward staff. The input for potential staff conferences would come from the very ward staff that would not have been fulfilling treatment or diagnostic needs. 4 trial transcript, at 231; *see* Findings of Fact 61 & 63.

67. Dr. Willis testified that he never instituted a program for periodic review of patient charts to determine whether ward staffs were adequately discharging

their treatment and diagnostic responsibilities. 3 trial transcript, at 89-90, 101-02, 122.

68. Dr. Melvin Heller, defendants' expert witness, acknowledged that the Superintendent and Clinical Director shared a responsibility to monitor what work their staff was performing, and how patients were responding to treatment programs. Dr. Heller testified that an institutional policy that called for no review of patients' status by a supervising clinician unless subordinate staff initiated inquiry would be "pretty bad." Dr. Heller testified that "I think every supervising clinician, mental health professional has the responsibility to go around and constantly evaluate their personal case load, of [if] they're responsible for the entire hospital's case load, Yes." 4 trial transcript, at 107, 110.

69. Dr. McGuire, who became Acting Superintendent after Dr. Shovlin's departure, testified that a review program was particularly necessary at Farview. Otherwise, the sole channel for access to treatment or evaluation was through the ward staff, particularly through the guards. As Dr. McGuire indicated, access to treatment was effectively being controlled by the guard population at the institution, and the practice was so common that the Superintendent and Clinical Director would have to be aware of it. *See* 2 trial transcript, at 199-201.

70. As testified by Dr. McGuire, a review of patient files would have revealed that ward staffs were not performing their duties properly and that patients were receiving inadequate psychiatric evaluation and treatment. Furthermore, the patient files would have revealed that the ward staffs lacked sufficient training. 2 trial transcript, at 159-60, 199.

71. As clinical Director, Dr. Willis had the most direct supervisory responsibility over the ward staffs and the manner in which they were discharging their duties. He had the best opportunity to observe deficiencies in the Farview treatment program.

72. The failure to exercise supervisory control fostered an attitude at Farview that the staff bore no responsibility to actually pursue patients for treatment.

73. Dr. Shovlin shared responsibility with the Clinical Director for supervising provision of treatment. Dr. Shovlin, like Dr. Willis, would have to have been aware of deficiencies in the Farview treatment program. Dr. Shovlin, however, stated that a patient's lack of treatment or evaluation would never come to his attention if the ward staff did not discharge their duties adequately. *See* Findings of Fact 46, 63; 4 trial transcript, at 231.

VI. TREATMENT OF PLAINTIFF AT FARVIEW

74. An examination of the plaintiff's medical records reveals no indication that plaintiff received, or participated in, a psychotherapy program during his stay at Farview. Plaintiff received three doses of a psychoactive drug in July of 1969, and he worked on the wards at various periods during his stay at Farview. The medication, however, was not continued long enough to have provided a therapeutic effect and there is no indication in the record as to why further administration of the drug was not pursued. The sole recommendation for therapy in plaintiff's records appears in 1973. Defendant Horan wrote an order for occupational therapy, recreational therapy and psychotherapy. No therapy was instituted pursuant to this order. 2 trial transcript, at 83, 162, 185;

3 trial transcript, at 79, 223-24; 4 trial transcript, at 40, 125; Plaintiff's Exhibit 2, at 14a: Plaintiff's Exhibit 3, at 402.

75. Plaintiff's medical record suggests that evaluation through ward notes was almost pro forma. No diagnosis or recommendation for treatment appears between 1941 and 1974. Many of the evaluations are mere paraphrases of the preceding ward note. Moreover, the notes are dated on the 28th day of April and October every year from 1944 until 1964. As many of these dates fall on weekends, it is unlikely that the evaluation actually took place on that date. Because ward staff conducted these evaluations of ward notes, the ward note system would hardly constitute an effective check on the quality of work being done by that staff. 2 trial transcript, at 81-82; 186-87; 4 trial transcript, at 209; Plaintiff's Exhibit 2, at 7-16.

76. Drs. Willis and Shovlin testified that plaintiff might have received therapy despite the silence of the medical records. These witnesses indicated that a separate drug card was kept indicating use of psychoactive drugs. Although the recordkeeping at Farview was primitive and unsatisfactory, the court cannot rely on this testimony as any indication that plaintiff received drug therapy. None of the plaintiff's ward notes mention use of drugs or any psychiatric treatment. Even Dr. Shovlin admitted that a ward physician would have been expected to note psychoactive medication. Dr. Shovlin also acknowledged that some indication of the use of psychoactive drugs might well have appeared in the ward notes, if the plaintiff had been medicated. 3 trial transcript, at 66-68, 71-72; 4 trial transcript, at 191, 203-09.

77. Plaintiff was never referred to a staff conference during his stay at Farview. Dr. Willis never reviewed plaintiff's file before this litigation. Dr. Shovlin had no recollection of reviewing plaintiff's records before preparation for trial. 3 trial transcript, at 57, 79; 4 trial transcript, at 202.

78. No members of the staff of the plaintiff's ward in the period from 1959 until 1969 testified at the trial. Thus, the sole basis for determining why plaintiff apparently received no treatment during this period consists of plaintiff's medical records and testimony concerning the treatment program at Farview. On the basis of plaintiff's records and the testimony underlying Findings of Fact 44-71, the court concludes that the ward staff failed to evaluate plaintiff adequately for any plan of treatment and failed to administer any psychiatric treatment.

79. Because no adequate system for review of a patient's file existed between 1955 and 1969, the failure of the ward staff to treat plaintiff was never brought to the attention of either the Superintendent or the Clinical Director. *See* Findings of Fact 73-77. Had plaintiff's case come to the attention of either the Clinical Director or the Superintendent, the medical policy at Farview would have called for plaintiff to receive antipsychotic drugs. 3 trial transcript, at 69, 124-25; *see* Findings of Fact 53-55.

80. The absence of a systematic review of patient treatment status and the attitude at Farview that the staff bore no responsibility to identify patients in need of treatment substantially contributed to plaintiff's lack of treatment.

81. The plaintiff offered no evidence sufficient to show that members of the staff at Farview abused him physically.

82. Mr. Fitzgerald arrived at Farview after the period in which plaintiff would have been likely to benefit from drug treatment. Mr. Fitzgerald, moreover, did not have treatment responsibilities. Finds of Fact 13, 14, 60.

83. The plaintiff has offered no evidence indicating that Mr. Truman had any treatment-related responsibility that could have affected plaintiff.

84. Ward physicians on R and S wards, the surgical wards, could either institute or continue psychiatric treatment for patients who were transferred to those wards. That treatment could include prescribing, continuing, and administering sedatives, tranquilizers or psychoactive drugs. However, if a patient from another ward saw a physician from R or S ward at the infirmary, and the patient needed psychoactive drugs, the primary responsibility for initiating the use of these drugs rested either with the physician supervising the patient's ward or with the clinical director. 3 trial transcript, at 211-16.

85. During his stay at Farview, Dr. Horan occupied a position as ward physician for "R" and "S" wards in which he primarily provided medical care. Although Dr. Horan could initiate psychiatric treatment, the responsibility was not his primarily. During the period in which plaintiff would have benefitted from drug treatment, plaintiff was on Dr. Horan's ward for only three brief periods. The first was from August 29, 1967 to September 3, 1967. The second was from September 3, 1968 until September 15, 1968. The third was from August 23,

1969 until September 15, 1969. Finding of Fact 82; Plaintiff's Exhibit 2, at 12a.

86. Dr. Powell bore ward physician duties with respect to plaintiff only when plaintiff was temporarily housed on "H" ward for four days. Dr. Powell otherwise provided plaintiff with medical treatment on several occasions after 1970. 3 trial transcript, at 25-26.

VII. PLAINTIFF'S PROBABLE RESPONSE TO TREATMENT

87. Dr. Melvin Heller, defendants' expert witness, testified that therapy modalities available before the advent of psychoactive drugs would not have been likely to improve the condition of a schizophrenic. Dr. McGuire, a psychiatric expert who formerly acted as Superintendent for Farview, testified that treatment during plaintiff's early institutionalization would have improved plaintiff's condition sufficiently to permit his discharge. Dr. Reiger, a second psychiatric expert for plaintiff agreed with Dr. McGuire and testified that plaintiff was competent to stand trial and free of any need for institutionalization throughout the early years of his stay at Farview. Dr. Reiger also testified that reasonable psychiatric evaluation would have disclosed this fact in 1941. The court, however, finds that whether or not plaintiff's condition rendered him incompetent to stand trial, therapy modalities available in the 1940's and early 1950's would not have materially improved his schizophrenia. 2 trial transcript, at 23, 24; 4 trial transcript, at 14-17.

88. All the experts who testified agreed that thorazine and related antipsychotic drugs were capable of reducing psychotic symptoms. Drs. McGuire and Reiger

testified that treatment with moderate doses of psychoactive drugs would almost certainly have restored plaintiff to a state permitting his release. Dr. Heller, however, believed that treatment with antipsychotic drugs would probably not have brought about more than a transitory improvement in the plaintiff's condition. Dr. Heller testified that the chronic nature of plaintiff's illness rendered response to psychoactive drugs less likely. 2 trial transcript, at 33-35; 217-18; 4 trial transcript, at 17 through 18, 20-22.

89. Dr. Heller read into the record an excerpt from a clinical psychiatry treatise that supported his contention that chronic schizophrenics respond less favorably to psychoactive drugs than acute patients. The treatise points out that a need for longer treatment and greater difficulty in adapting to non-institutionalized life are common problems for chronic schizophrenics. Nevertheless, the court believes that plaintiff's condition would have improved sufficiently to make his discharge possible had he received treatment with antipsychotic drugs. Dr. Heller himself admitted that he would have treated plaintiff with such drugs had it been his decision and would have approached plaintiff's condition much more aggressively. 2 trial transcript, at 188; 3 trial transcript, at 21, 23-24, 104-05; 4 trial transcript, at 27-29.

90. Had plaintiff received treatment, his release would have required some degree of aftercare. Particularly with chronic schizophrenics, greater difficulty could be expected in adjustment to life outside the institution. Such aftercare would have had to come from friends, family or a professional agency. 2 trial transcript, at 66-67.

91. Treatment with antipsychotic drugs would have been beneficial to plaintiff until other physical factors made the risk of that treatment too great. By the early 1970's, the plaintiff's advanced age alone would have rendered the risks of such effects too great. By the late 1960's and early 1970's, the plaintiff had also developed circulatory problems and diabetes. These physical problems would have counseled against treatment with antipsychotic drugs. 3 trial transcript, at 225-26; 4 trial transcript, at 84-85.

92. Therefore, during the period between 1955 and 1969, plaintiff could have been successfully treated with antipsychotic drugs. Adequate evaluation of plaintiff would have revealed this.

DISCUSSION

From the foregoing, the conclusion follows that plaintiff languished for nearly thirty-five years in an institution for the mentally ill largely without psychiatric treatment or evaluation. Undoubtedly, this incarceration perpetrated a grave injustice upon plaintiff, who, although mentally ill, presented no danger either to himself or to others. Resolution of this civil action for damages, however, turns upon the much narrower question whether these defendants culpably deprived plaintiff of rights secured under the United States Constitution. For example, a mere showing of negligence by hospital officials is not enough. Plaintiff can demonstrate his entitlement to damages only by proving the essential elements of a cause of action under Section 1983 of Title 42 of the United States Code.

Plaintiff bears the burden of proof on three essential issues.[1] First, the injury sustained must arise to constitutional magnitude. Second, the plaintiff must point out an affirmative link between the conduct of these defendants and the constitutional violation. Third, the defendants must have foreseen that their course of action, or inaction, would cause injurious consequences to the plaintiff.

The third element of plaintiff's burden of proof, defendants' state of mind, also relates to the question of immunity. Once plaintiff has discharged his burden of proof, the defendants may nevertheless assert a qualified immunity from damages. If the defendants satisfy the court that their conduct, however harmful its results, was undertaken in the good faith fulfillment of their duties, they are shielded from liability.

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[1]One element of a cause of action under § 1983 is not in dispute. Whether the defendants acted under color of state law is a threshold question for a § 1983 liability. *See* Parratt v. Taylor, 101 S. Ct. 1908, 1913 (1981). None of these defendants have denied that they acted under color of state law. Indeed, such a denial would be unavailing for public officials employed by the state mental institution. The "color of state law" concept encompasses both acts taken by state officials pursuant to state law and any "[m]isuse of power possessed by virtue of state law and made possible only because the wrongdoer was clothed with the authority of state law." Monroe v. Pape, 365 U. S. 167, 184 (1961), *overruled in part on other grounds* Monell v. New York Dept. of Soc. Serv., 436 U. S. 685 (1978); *see* Brown v. Miller, 631 F. 2d 408 (5th Cir. 1980). As the United States Supreme Court noted in *Parratt v. Taylor*, state employees who, at the relevant time, hold positions of authority cannot seriously contend that their acts are other than under color of state law. 101 S. Ct. at 1913. Accordingly, the court must resolve this other essential element of a § 1983 cause of action in plaintiff's favor.

Discussion of these issues provides the organizational focus for this Memorandum. The first subdivision will consider whether plaintiff's institutionalization deprived him of his constitutional rights. The second subdivision will consider the extent of the defendants' personal involvement in plaintiff's allegedly wrongful incarceration. The third subdivision will consider first, whether plaintiff's proof demonstrates culpability on the part of any of the defendants, and second, whether any of the defendants offered sufficient exculpatory evidence to assert a qualified immunity from damages. Before proceeding, each of the three issues concerning liability merits preliminary discussion.

Plaintiff's very presence in a federal forum depends upon establishing the first element, the deprivation of a right, privilege or immunity secured by the United States Constitution. Federal courts, which are courts of limited jurisdiction, may only consider cases authorized by federal statute. Section 1983, the statute relied upon in this action, requires the deprivation, under color of state law, of Fourteenth Amendment rights.

Traditionally, state law has governed the care and control of the mentally ill. The Commonwealth of Pennsylvania, throughout the period of plaintiff's institutionalization, had comprehensive mental health codes governing the manner in which plaintiff should have been treated. Although construction of these laws has relevance for analyzing the duties that these defendants owed to plaintiff, any violation of Pennsylvania law is an issue independent of the constitutional question. Whether confining plaintiff indefinitely at Farview contravened Pennsylvania's mental health codes, any deviation from state

procedures must also have impinged upon federal rights. Only if defendants' treatment of plaintiff bore no rational relation to the Commonwealth's interests in caring for and controlling the mentally ill, would a federal cause of action under § 1983 become appropriate.

Once plaintiff satisfies this initial burden, he must go on to prove the second element, personal involvement by the defendants. Public officials do not incur liability merely by occupying positions of authority relative to plaintiff. Their conduct must comprise a substantial causative factor in the constitutional injury. On the basis of the court's findings, it is clear that none of these defendants did anything of therapeutic value for plaintiff's mental illness. Obviously, their inaction alone does not assure that they have the slightest "personal involvement." When the allegations of involvement are based on neglect, the plaintiff must persuade the court that the defendants' inaction occurred in the context of an affirmative duty to do something. Here, the requirements of state law and the scope of the defendants' official duties become crucial. Those defendants who bore direct responsibilities towards plaintiff arising either from state law or from the nature of their positions cannot necessarily deny their personal involvement in his continuing confinement merely because they never treated or diagnosed him.

Even establishing a constitutional deprivation and causation, however, does not discharge the entire burden. Whether any defendants foresaw the injurious consequences of their inaction provides a final essential element. Precisely the state of mind with which a public official must act in order for liability to attach under the Civil Rights Act remains an unresolved question. In this

case, however, all of the defendants claim a qualified immunity from damages. This claim of immunity places the burden on plaintiff of offering evidence that the defendants intended to injure him.

At the time that these defendants acted, no clear constitutional decisions had delineated the scope of the rights of the mentally ill. In the absence of a clear constitutional mandate, public officials need only respond in damages for actions taken in subjective bad faith. Although, ultimately, the defendants bear the burden of proving their good faith, plaintiff must first establish that the defendants had a sufficient understanding of the likely consequences of their inaction to raise at least an inference that they were indifferent to the substantial certainty of harm to plaintiff. Only upon offering such evidence does the burden of showing good faith fall upon the defendants.

This brief outline of the issues sketches the framework for the more detailed discussion that follows. On the basis of these facts, the court finds that plaintiff has established a violation of the Fourteenth Amendment. Plaintiff's evidence, however, provides a basis for a finding of causation only with respect to Mr. Fitzgerald, Dr. Shovlin and Dr. Willis. As to both Dr. Shovlin and Dr. Willis, plaintiff's evidence also suffices to show knowledge that their inaction would injure plaintiff and other patients at Farview. Nevertheless, both Dr. Willis and Dr. Shovlin have established that they conducted themselves in subjective good faith.

I. THE EXISTENCE OF A RIGHT SECURED BY THE CONSTITUTION

Plaintiff proceeded to trial on the basis of two alternative theories of constitutional violation. The first alleged violation of his civil rights resulted from the defendants' failure to discover that long-term institutionalization was unnecessary for him. Plaintiff argued that the Constitution and state law required defendants to return plaintiff to the committing court for disposition of his criminal charges upon learning that he no longer needed care at Farview. The second violation allegedly resulted from failure to supply psychiatric treatment to plaintiff during his stay at Farview. Plaintiff argued that, once he was committed involuntarily, both state law and the Constitution imposed a duty on the Commonwealth and its representatives to treat him.

While the Fourteenth Amendment does not control every particular of the state's relationship with the mentally ill, due process does limit the exercise of the state's power over the mentally ill. The procedural guarantees of the due process clause insure that sufficient safeguards surround the commitment of the mentally ill, e. g., *Addison v. Texas,* 441 U. S. 418 (1978); *Vitek v. Jones,* 445 U. S. 80 (1979); *Jackson v. Indiana,* 406 U. S. 715 (1972), and the substantive guarantees of due process require that the state adopt methods reasonably related to its interests in controlling the mentally ill. *See O'Connor v. Donaldson,* 422 U. S. 563, 575-76 (1975) (indefinite commitment of mentally ill must have continuing basis that is adequate under constitution); *cf. Jackson v. Indiana,* 406 U. S. at 738 (due process demands at least that nature and duration of confinement bear a rational relationship

to purpose of confinement). *See also Nebbia v. New York*, 291 U. S. 502, 525 (1934) (to comport with due process government must regulate reasonably and methods adopted may be neither arbitrary nor capricious). Thus, whether a particular individual's confinement comports with due process will turn on the question whether that confinement represents a reasonable implementation of the state's purpose for involuntarily withdrawing the person from society. *O'Connor v. Donaldson*, 422 U. S. at 575; *Jackson v. Indiana*, 406 U. S. at 737-38; *McNeill v. Director of Patuxent Institution*, 407 U. S. 245, 249-50 (1972).

Generally, the states have invoked three justifications for involuntary commitment. If a mentally ill individual presents a danger of injury to the public, involuntary commitment may represent an appropriate exercise of the state's police power. *O'Connor v. Donaldson*, 422 U. S. at 373; Note, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1212-23 (1974) [hereinafter cited as Harvard Note]. Under its parens patriae authority, states have invoked two further interests: providing care for individuals whose mental illness renders them unable to care for themselves and administering treatment to an individual in order to alleviate a mental illness. *See O'Connor v. Donaldson*, 422 U. S. at 573-74; *Jackson v. Indiana*, 406 U. S. at 736-37; Harvard Note, supra at 1217-22.

Substantive due process limitations constrain the state in the application of these interests both by prohibiting confinement of an individual who does not fall with the scope of the state's power, *Jackson v. Indiana*, 406 U. S. at 738, and by requiring that the state continue

to restrain the individual only so long as the justification for confinement exists. *O'Connor v. Donaldson*, 422 U. S. at 574-76. Plaintiff's two claims, that the Constitution guaranteed him a right to be returned to the committing court upon a determination that further institutionalization was not necessary, and that he had a right to receive treatment, are alternative embodiments of the state's duty under the due process clause to a patient committed on the basis of a need for psychiatric treatment. Plaintiff has argued throughout these proceedings that he either did not meet Pennsylvania's definition of mental illness or that he met it solely by virtue of a need for treatment that he never received. Accordingly, he claims that the state deprived him of his due process rights when they failed to either return or treat him.

The court has found that plaintiff did suffer from mental illness during his confinement at Farview. The court has also concluded that the illness never manifested itself in behavior that rendered plaintiff dangerous to others. Furthermore, the court has found that the mental illness never disabled plaintiff from caring for himself. The court's findings, however, do reflect that, at least after the introduction of phychoactive drugs, plaintiff would have benefited from psychiatric treatment.

Inexorably, then, the conclusion follows that constitutionality of plaintiff's confinement depends on whether the state's methods in continuing his institutionalization during the 1940's and early 1950's, when no effective treatment was available for his condition, and during the late 1950's and 1960's when no effort was made to provide treatment, were rationally related to the purpose of the commitment.

The court concludes that the state's treatment of plaintiff did not comport with due process. Plaintiff's confinement exceeded the state's authority in the period before the development of effective methods of treatment. Notwithstanding plaintiff's illness and the pendency of criminal charges, none of the asserted bases of state power over the mentally ill had application to him. Plaintiff's evidence demonstrates that he was never a dangerous individual, either to himself or to others. Before the introduction of psychoactive drugs, the defendants themselves concede that no mode of psychiatric treatment held any promise for improving plaintiff's condition. Since withholding treatment after it became available ran contrary to the state's interest in incarcerating him, plaintiff's stay at Farview represented an abuse of the state's authority even after the introduction of that treatment. *See Romeo v. Youngberg*, 644 F. 2d at 165 (where treatment is basis for commitment court's duty is to insist on appropriate treatment or release). As the court in *O'Connor* observed:

> A finding of "mental illness" alone cannot justify state's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that the term can be given a reasonably precise content and that "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.
>
> May the state confine the mentally ill merely to insure them a living standard superior to that enjoyed in the private community? That the state has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere existence of mental illness does not disqualify a per-

son from preferring his home to the comforts of an institution. Moreover, while the state may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom on their own or with the help of family or friends.

May the state fence in harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the state, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.

In short, a state cannot constitutionally confine without more a non dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.

422 U. S. at 575-76 (citations omitted); *see Romeo v. Youngberg*, 644 F. 2d at 165 n. 42 (where one committed on grounds of need for treatment, lack of available treatment and failure to release violates Constitution).[2]

The conclusion that plaintiff's incarceration exceeded the state's power is consistent with Pennsylvania law itself. The three Pennsylvania statutes in effect during the plaintiff's confinement codified each of the three rationales traditionally invoked by the states. *See* The Men-

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[2]In light of the court's findings, this case presents no occasion to consider treatment rights of patients committed on basis of dangerousness to themselves or others. Furthermore, the court's finding that plaintiff did not receive psychiatric treatment obviates the need to consider standards to judge the adequacy of any treatment plan instituted by the personnel at Farview.

tal Health and Retardation Act of 1966, Art. I, § 102, Pub. L. 6, 1966 Pa. Laws, 3d Spec. Sess. 96, 99; The Mental Health Act of 1951, Art. I, § 101 (11), Pub. L. 141, 1951 Pa. Laws 533, 539; The Mental Health Act of 1923, Art. I, § 103, Pub. L. 414, 1923 Pa. Laws 998, 998. In order to subject an individual to involuntary confinement, each law required that the person suffer from mental illness within the meaning of the Act. The 1966 Act reads in pertinent part:

> "Mental disability" means any mental illness, mental impairment, mental retardation, or mental deficiency, which so lessens the capacity of a person to use his customary self-control, judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under care as provided in this act.
>
> The Mental Health and Retardation Act of 1966, Art. I, § 102.

The 1951 Act provides in pertinent part:

> (11) "Mental illness" shall mean an illness which so lessens the capacity of a person to use his customary self-control, judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under care.
>
> The Mental Health Act of 1951, Art. I, § 101 (11).

The 1923 Act states in part:

> "Mental illness," "mental disease," "mental disorder," shall mean an illness which so lessens the capacity of a person to use his customary self-control, judgment and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance or control.
>
> The Mental Health Act of 1923, Art. I, § 103.

These definitions, which are substantially similar, provide a threshold question for commitment under the provision of any of these acts.[3] A finding of mental illness does not itself provide a sufficient basis for the commitment. Not only must the nature of the illness inflict a disability lessening the individual's capacity for self-control, judgment and discretion, *e. g., Commonwealth v. Glassard,* 385 Pa. 312, 319, 128 A. 2d 258 (1958); *Commonwealth v. Moon,* 383 Pa. 18, 28-29, 117 A. 2d 96 (1955) (1951 Act), but also the lessening of self-control must render commitment to a state hospital necessary or advisable. *See Commonwealth ex rel. Cummins v. Price,* 421 Pa. 396, 405-06, 218 A. 2d 758, 763 (1966) (a person does not fall within the terms of the 1951 Act if he requires no care in a mental hospital). By conditioning placement of the mentally ill on the need for custody, control or treatment, the statute encompasses all three justifications for commitment. Clearly, persons dangerous to themselves or others would fall within these definitions. The need for treatment independently provides sufficient need for institutionalization to justify commitment under Pennsylvania law. *See Commonwealth ex rel. Tate v. Shovlin,* 205 Pa. Super. 370, 374, 208 A. 2d 924, 927 (1966) (by acknowledging in a petition for habeas corpus that

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[3]The court notes that the 1966 Act provides an alternative commitment procedure for pretrial detainees who lack capacity to stand trial. Plaintiff's original commitment, notwithstanding its pretrial nature, however, took place under the involuntary civil commitment procedure. See The Mental Health Act of 1923, Art. I, § 308 Pub. L. 414, 1923 Pa. Laws 998, 1001-04 (requiring commitment of prisoners incompetent to stand trial under the involuntary civil commitment procedure). Since plaintiff was never recommitted under the relevant provision of the 1966 Act, that provision, The Mental Health and Retardation Act of 1966, Art. IV, § 408, is not relevant here.

he suffers from mental illness requiring treatment, patient admits that he falls within state's *parens patriae* power and thus is an appropriate subject under 1951 Act).[4]

Pennsylvania courts have consistently recognized that the definition of mental illness under the various mental health acts combine the medical concept of mental illness with the additional element of the lessening of self-control and the need for care in a mental hospital. *E. g., Commonwealth v. Moon*, 383 Pa. at 28-29, 117 A. 2d at 102. In *Commonwealth v. Ballem*, 391 Pa. 626, 629, 139 A. 2d 534, 540-41 (1958), the Pennsylvania Supreme Court made this explicit. "Moreover, as we held in the *Moon* case . . . the defendant convicted of murder with the death penalty imposed can be affected with a mental illness—

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[4]Despite the existence of no definite interpretation of the 1923 Act by the Pennsylvania courts, the nearly identical nature of the language in each compels the conclusion that they share the same meaning. Moreover, the Pennsylvania Department of Justice has taken the position that the need for custody, care and treatment is an essential element for commitment under The Mental Health Act of 1923. See Department of Justice Opinion to the Hon. Charley Barber, Secretary of Welfare, Shock Treatment in State Hospitals (May 18, 1948), *reprinted in* 64 D. & C. 14 (1948). The opinion states:

> From the foregoing definitions, it would be observed that an essential characteristic of mental illness is the necessity to control the patient; and that the "cure" of mental patients is predicated largely on custody, detention and discipline; therefore, the rules and practices for the care and treatment of mental patients must not be confused with those governing the voluntary commitment of patients. . . .
>
> *Id.* at 14.

Consequently, the 1923 Act imposes the same threshold question concerning mental illness, its effects, and the advisability of institutionalization.

in that case dementia praecox of the paranoid type—and nevertheless not come within the statutory definition of mental illness and thus not a proper subject for commitment." *Id.* at 389, 139 A. 2d at 541.

While the question of the permissibility of plaintiff's commitment under state law does not directly influence the conclusion that plaintiff was deprived of a right secured by the Constitution, state law duties do bear a significant relation to the remaining questions before the court. Having determined that the plaintiff's incarceration violated due process, the court must next consider whether any of these defendants involved themselves in this constitutional deprivation and, finally, whether any of the defendants acted with the state of mind necessary to impose liability upon them under the Civil Rights Act.

II. THE PERSONAL INVOLVEMENT OF THESE DEFENDANTS

A plaintiff, even one whose rights under the Constitution have been violated, must demonstrate a sufficient casual link between the violation of these civil rights and the conduct of the particular defendants charged in order to obtain relief. *Rizzo v. Goode,* 423 U. S. 362, 371-72, 377 (1976); *see Monell v. New York Department of Social Services,* 436 U. S. 658, 693 (1978) (absent causation, § 1983 liability does not attach). Establishing an "affirmative link" between the injury and the defendants' conduct is essential to the showing of causation. *Rizzo v. Goode,* 423 U. S. at 371-72, 377. Although this plaintiff suffered a deprivation of civil rights arising from an institutional pattern of neglect rather than one flowing from affirmative injurious acts, a plaintiff may establish such an "affirmative link" even without affirmative acts.

Specifically, plaintiff argues that neglect suffices as a basis for liability because the defendants were charged both under state law and by virtue of their positions at Farview with a duty to evaluate and treat him. Indeed, failure to take action can form grounds for liability under § 1983. *See e.g., Duchesne v. Sugarman*, 566 F. 2d 817, 832 (2d Cir. 1977) (where conduct of supervisory official relates directly to denial of rights, either action or inaction can satisfy causation requirement). Supervisory personnel, for example, may expose themselves to liability by knowing of, and acquiescing in, unconstitutional conduct by subordinates. *E.g., Hampton v. Holmesburg Prison Officials*, 546 F. 2d 1077, 1080 (3d Cir. 1976). A civil rights action may also arise from a failure to train, supervise or control subordinates adequately. *E.g., McClelland v. Facteau*, 610 F. 2d 693, 696 (10th Cir. 1979); *Owens v. Haas*, 601 F. 2d 1242, 1246-47 (2d Cir. 1979). Any of these theories of liability under § 1983 contemplate the imposition of liability without any affirmative act on the part of the supervising official.[5]

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[5]The Second Circuit Court of Appeals in *Duchesne* relied in part, on Burton v. Wilmington Housing Authority, 365 U. S. 715 (1961), quoting from that opinion as follows:

> [N]o state may effectively abdicate its responsibilities by either ignoring them or failing to discharge them, whatever the motive may be. It is no consolation to an individual denied the equal protection of the laws that it was done in good faith. . . . By its inaction, the Authority, and through it the state, has not only made itself a party to the refusal of service, but has elected to place its power, property and prestige behind the admitted discrimination.

Id. at 725 (quoted in Duchesne v. Sugarman, 566 F. 2d at 832).

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Where neglect forms the basis of asserted liability under the Civil Rights Act, the cause of action presupposes the existence of some duty or obligation to take action. *E.g., Johnson v. Duffy*, 588 F. 2d 740, 743 (9th Cir. 1978). Given the existence of such a duty arising under state or local law, the failure to take action can work as real a denial of rights upon a person as taking action can. *E.g., Sims v. Adams*, 537 F. 2d 829, 831-32 (5th Cir. 1976).[6] An examination of the Pennsylvania mental health schemes has persuaded the court that, during the period of plaintiff's confinement, the staff of a mental health institution did bear some duty to provide care, including psychiatric treatment, to its patients.

The Pennsylvania courts have held that a civilly committed mental patient should be discharged if he no longer

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As the Second Circuit Court noted, this reasoning militates against a holding that inaction can form no basis for a finding of causation, provided that the inaction relates directly to the constitutional violation. Although the issue of good faith certainly has relevance to the issues of damages, knowing acquiescence in an unconstitutional state of affairs can certainly supply a causal link sufficient under Rizzo.

[6]Imposing the requirement of duty for causes of action based on a failure to act comports with the principles of construing § 1983 in harmony with common law concepts of tort immunity and defense. *See generally* Imbler v. Pachtman, 424 U. S. 409, 418 (1976); Douhit v. Jones, 619 F. 2d 527, 533 (5th Cir. 1980); Allen v. Dorsey, 464 F. Supp. 44, 47 (E. D. Pa. 1978). The law of false imprisonment, the tort most directly analogous to the instant denial of civil rights, permits imposition of liability for inaction, but only on the showing of duty. See Restatement (Second) of Torts, § 45, Comment A (1965). Comment A notes:

> In the absence of any duty to release the other, or to aid in his release, the actor's refusal to do so, even though intended to continue the confinement, does not make him liable for false imprisonment.

Id.

suffers from mental illness within the meaning of the Act. *Commonwealth ex rel. Wolenski v. Shovlin,* 419 Pa. 35, 40 and n. 5, 213 A. 2d 227 (1965). Indeed, each of the mental health acts explicitly confers upon patients a right to discharge when they have recovered. *See* The Mental Health Act of 1923, Art. VI, § 601(g), Pub. L. 414, 1923 Pa. Laws 998, 1020 (patient to be discharged when, in medical attendant's opinion, he is restored to reason and can manage his affairs); The Mental Health Act of 1951, Art. VIII(a), § 801(b), Pub. L. 141, 1951 Pa. Laws 533, 569 (when restored to reason and competent to manage own affairs); The Mental Health and Retardation Act of 1966, Art. IV, § 423, Pub. L. 96, 1966 Pa. Laws 3d Special Sess. 96, 118 (when care and treatment no longer necessary). Since restoration to reason must be construed in light of the statutory definition of mental illness, a patient who no longer meets the statutory definition is entitled to discharge. *Commonwealth ex rel. Wolenski v. Shovlin,* 419 Pa. at 40 & n.5, 213 A. 2d at 329-30 & n. 5; *see Commonwealth v. Jenkins,* 21 D. & C. 2d 413, 422-23 (Q. Sess. Ct. Phil Co. 1960) (patient should be discharged under 1951 Act when no longer mentally ill within the meaning of the Act). *See also Commonwealth ex rel. Tate v. Shovlin,* 174 Pa. Super. 609, 611 (1953) (discharge proper under 1951 Act when patient is restored to "mental health" and released consistent with public welfare and safety).

Apparently no Pennsylvania court has addressed a question concerning the right of involuntarily committed person to receive psychiatric treatment.[7] In 1968, the

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[7]In one case, the Pennsylvania Superior Court declined to consider a question of adequacy of treatment. *See* Common-

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Pennsylvania Supreme Court considered an appeal of a juvenile contesting his transfer from the Pennhurst State School, "a Commonwealth operated hospital-school for mental defectives," to the State Correctional Institute at Dallas, Pennsylvania. Among the grounds asserted by that petitioner, was the claim that a commitment to the Dallas Institution would deprive him of an opportunity to receive treatment. The court observed:

> Admittedly, *Rouse v. Cameron*, [373 F. 2d 451 (D. C. Cir. 1966)] is authority for the proposition that courts, under proper circumstances, will pass judgment on the treatment being afforded persons confined to state institutions. However, for any one of a number of reasons, *Rouse* has absolutely no application to this case. First, and most significant, *Rouse* proceeds on the notion that one has a constitutional right to treatment when involuntarily committed to a mental hospital following an acquittal, by reason of insanity, of a criminal offense. This result flows *not* from the mere fact that one is in custody, but rather from the *nature* of that remedy. Relator in *Rouse* was not in a penal institution, he was in a mental hospital whose justification for confining him was his need for medical treatment. Having been found guilty of no crime, he could not be kept in custody for any reason other than treatment. It follows inexorably, therefore, that the court in *Rouse* had no choice but to find relator entitled to proper treatment. To hold otherwise would be tantamount to permitting involun-

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wealth ex rel. Tate v. Shovlin, 205 Pa. at 374, 208 A. 2d at 926-27. That action, however, concerned a claim of inadequacy of treatment rather than the absence of it altogether. Moreover, that question came before the Superior Court in the form of a petition for a writ of habeas corpus. Such an action raised only the narrower question of a patient's right to unconditional release. Accordingly, that case sheds little light on the present question.

tary hospitalization for no reason other than pure confinement, an obvious due process violation.

Commonwealth v. Williams, 432 Pa. 44, 60, 246 A. 2d 356, 365 (1966).

While none of the Mental Health Acts themselves nor Pennsylvania case law, for the most part, speak directly of a right to treatment, a duty to provide treatment is implicit in the Acts. As the court has already noted, the need for care in a mental hospital is a prerequisite for institutionalization. Undoubtedly, the concept of "care" encompasses administering some form of psychiatric treatment. An examination of the definitions of "care" in either the 1923 or 1951 Act reinforces this conclusion. The 1923 Act reads, in part:

> Care shall include reception, detention, custody, care, treatment, maintenance, support, segregation, education, culture, training, discipline, improvement, occupation, employment, medical and surgical treatment and nursing, food, and clothing.
>
> The Mental Health Act of 1923, Art. I, § 102, Pub. L. 414, 1923 Pa. Laws 998, 999.

The 1951 Act reads, in pertinent part:

> Care shall include reception, detention, transfer, parole, discharge, custody, care, treatment, maintenance, support, segregation, education, culture, training, discipline, improvement, occupation, employment, medical and surgical treatment, and nursing, food and clothing.
>
> The Mental Health Act of 1951, Art. I, § 102(1), Pub. L. 141, 1951 Pa. Laws 533, 538.

The 1966 Act does not define care, but does contain the following provision:

> In patient services means diagnosis, evaluation, classification, care, treatment or rehabilitation rendered to a mentally disabled person admitted or committed to a facility for a continuous period of 24 hours or longer.
>
> The Mental Health and Retardation Act of 1966, Art. I, § 102, Pub. L. 96, 1966 Pa. Laws, 3d Special Sess. 96, 99.

In the case of the 1923 and 1951 Acts, care incorporates the concept of "treatment." Manifestly, treatment denotes psychiatric as opposed to medical or surgical treatment; otherwise the separate inclusion of medical and surgical treatment in the definition of care would create a redundancy. Accordingly providing psychiatric care is an essential part of the statutory scheme.

The defendants, nevertheless, contend that the statutes impose no duty to provide "care," on the personnel in a mental institution, at least in the sense of administering psychiatric treatment. In view of the definitions contained in each act, adopting that argument would require a strained interpretation of the Pennsylvania Mental Health programs. These statutes define "mental hospitals" as facilities primarily devoted to the administration of "care." *See* Mental Health and Retardation Act of 1966, Art. I, § 102 (" . . . a residential facility for the diagnosis, *care*, and *treatment* of the mentally disabled . . . ") (emphasis supplied); The Mental Health Act of 1951, Art. I, § 102 (" . . . any State, semi-State, or licensed hospital, institution, school, or place . . . for the *care* of mental patients") (emphasis supplied). That the Commonwealth of Pennsylvania would include psychiatric treatment in its definition of "care," define "mental hospitals" as facilities for the "care" of the mentally ill and yet not contemplate pro-

viding care, including psychiatric treatment, is an insupportable proposition which I reject.[8]

While the Pennsylvania Mental Health Acts appear to impose a generalized duty to provide psychiatric care and evaluation, the sufficiency of inaction as a basis for a showing of personal involvement turns upon a more particularized duty to act. As a pre-condition for any liability, these defendants would have to bear direct or supervisory responsibility for discharging the statutory duty with respect to plaintiff. Yet, permitting imposition of liability on a supervisor solely on the basis of the statutory duty and that supervisor's right to control subordinates would amount to imposition of vicarious liability. Such liability on a respondeat superior theory is repugnant to the policies behind the Civil Rights Acts. *See Monell v. New York Department of Social Services*, 436 U. S. at 693.

For the purposes of proving personal involvement, the plaintiff must demonstrate that the defendants' inaction occurred in the face of knowledge that the institution was failing to provide adequate diagnostic and treatment procedures. Acquiescence in the face of such knowl-

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[8]In an opinion of the Department of Welfare, the Pennsylvania Department of Justice itself construed the 1923 Act to empower State mental institutions to administer electric shock treatments. This authority, according to the opinion, proceeded partly from the power and duty of institutions to administer care, and partly from the need for custody, control and discipline inherent in the concept of institutionalization. Department of Justice Opinion to the Hon. Charley Barber, Secretary of Welfare, Shock Treatment in State Hospitals (May 18, 1948), *reprinted in* 64 D. & C. 14 (1948). Moreover, the Quarter Sessions Court of Philadelphia, in 1960, construed the 1951 Act to impose a duty of providing psychiatric treatment. Commonwealth v. Jenkins, 21 D. & C. 2d 413, 425 (Q. Sess. Ct., Phil. Co. 1960).

edge can, of course, be proved circumstantially by evidence of the existence of failures to diagnose or treat at Farview combined with proof of the institutional context in which such inaction took place. *E. g., Doe v. New York Department of Social Services,* 649 F. 2d 134, 135 (2d Cir. 1981); *Wright v. McMann,* 460 F. 2d 126, 134-35 (2d Cir. 1972); *Cameron v. Montgomery County Child Welfare Service,* 471 F. Supp. 761, 764-65 (E. D. Pa. 1979); *Santiago v. City of Philadelphia,* 435 F. Supp. at 152-53.

Once the existence of a failure to provide adequate treatment and diagnostic duties has been shown, the nature of the officials' duties, the available sources of knowledge about subordinates' conduct, and the extent to which the officials formulate or execute policies that encourage or aggravate the institutional failures may all provide indicia of personal involvement by the defendant. *Id.* at 151. For supervisory officials, the greater the degree of direct control over the subordinates, the less specific need their knowledge of the plaintiff's circumstances be. *Cameron v. Montgomery County Child Welfare Service,* 471 F. Supp. at 764. Where close and firm lines of authority exist between supervisor and subordinate in an institutional context, the supervisor has more immediate access to subordinates, greater opportunity to direct their conduct and more assurance that his directives will be followed. *Doe v. New York City Department of Social Services,* 649 F. 2d at 142. Thus, when a supervisor implements policies that encourage an unlawful state of affairs, that course of action can provide an inference that the supervisor is acquiescing in the misdeeds of his subordinates. *Wright v. McMann,* 460 F. 2d at 135; *Santiago v. City of Philadelphia,* 435 F. Supp. at 152.

Although this court's factual findings reflect that a failure to provide adequate psychiatric care or evaluation characterized conditions generally at Farview, the court must conclude that the nature of several defendants' duties with respect to plaintiff bore too attenuated a relationship to warrant any finding of personal involvement. Undoubtedly, ward physicians at Farview bore the most immediate responsibility for diagnosing and treating the plaintiff. *See* Findings of Fact 48, 57. Accordingly, ward physicians would have exercised the greatest degree of authority and control over treatment decisions for a particular patient. Drs. Horan and Powell, however, are the only ward physicians named as defendants. The court has specifically found that neither physician ever bore ward physician's duties with respect to this plaintiff. Finding of Fact 85. The evidence of record falls far short of illuminating a sufficient causal link between the conduct of Drs. Powell and Horan and any injury to this plaintiff. On this basis alone, no award of damages against Drs. Powell and Horan is warranted. The ward physician or physicians who had this responsibility during the pertinent time period have not been identified and, of course, are not named defendants. Why Drs. Powell and Horan were joined as defendants, and not the ward physicians who were actually involved with plaintiff, does not appear in the record.

While the evidence demonstrates that guards at Farview could initiate inquiry into a patient's treatment status or condition, *see* Findings of Fact 50, 59, the record does not reveal that guards in supervisory positions were empowered to formulate policy concerning treatment or staff conferences. On the contrary, policy making with respect

to treatment and staff conferences rested with the Superintendent and Clinical Director. *See* Findings of Fact 46-47, 63-65, 71. Even assuming that defendant Truman may be fairly chargeable with knowledge of the state of affairs at Farview, plaintiff's evidence does not demonstrate that he implemented policies that aggravated or encouraged the deficiencies in the treatment program at Farview. The quality of the evidence as it pertains to defendant Truman is clearly insufficient to link him causally to any deprivation of plaintiff's constitutional rights.

For much the same reason, the court must reject a causation finding with respect to Mr. Fitzgerald on the issue of treatment. Mr. Fitzgerald did bear a responsibility for ascertaining the status of patient commitments. Nevertheless, the record establishes that Mr. Fitzgerald had no responsibility for instituting or evaluating the treatment program at Farview. Moreover, Mr. Fitzgerald only arrived at Farview in 1971. Since the court has found that plaintiff would not have benefited from treatment after the late 1960's, plaintiff has not carried his burden of proving an affirmative link between any act of Mr. Fitzgerald and the failure of the staff at Farview to provide psychiatric treatment or evaluation for plaintiff.

For causation purposes, however, this finding with respect to Mr. Fitzgerald does not necessarily eliminate him from the case. If the status of plaintiff's commitment had been reviewed even in the 1970's, the inappropriateness of continued institutionalization at Farview would have been manifest. Mr. Fitzgerald bore the responsibility for conducting the type of review that would have iden-

tified the questionable nature of plaintiff's commitment. Furthermore, the record establishes that Mr. Fitzgerald acquiesced in a policy of reviewing the status of commitments only when the institution received inquiries from third parties. For present purposes, the court finds that this evidence makes a sufficient showing of causation against Mr. Fitzgerald on the issue of failure to return plaintiff to the committing court for disposition of the criminal charges pending against him.

Turning to defendants Willis and Shovlin, the factors outlined above compel a finding of causation. Both bore ultimate responsibility for delivering medical and psychiatric treatment to patients. Both exercised authority and control over subordinate personnel charged with providing care to Farview's patients. Both would have to be aware of the inadequacy of the diagnostic and treatment procedures. Although Dr. Willis had more immediate responsibility for formulating and implementing policies and practices relative to patient care, Dr. Shovlin had ultimate authority to approve institutional policy and the duty to supervise Dr. Willis's operation of the medical office.

The chief factor contributing to plaintiff's continued, wrongful confinement at Farview was the failure of Farview's medical staff to evaluate patients for release or treatment on any but the most haphazard basis. This lack of treatment or evaluation flowed from the absence of any systematic review of patients. Combined with the deficiency of staff training and the disinclination of ward staff to involve themselves in psychiatric treatment generally, this lack of a review program allowed patients to remain indefinitely, absent some fortuitous event such as interest

in a particular patient by a staff member, or third party inquiries about a patient's status. Assuming that Drs. Shovlin and Willis were aware of this state of affairs, their failure to take corrective action would constitute a substantial causative factor in plaintiff's constitutional injury.

The court has already concluded that the deficiencies in Farview's treatment program were so apparent that the supervisors responsible for delivery of psychiatric care would have been aware of it. An integral part of the showing of a causal link between the defendants' conduct and the plaintiff's injury is the question concerning the state of mind of the defendants. The Third Circuit Court of Appeals has spoken of "knowledge and acquiescence" as the relevant standard. *Hampton v. Holmesburg Prison Officials*, 546 F. 2d at 1030. *See Santiago v. City of Philadelphia*, 435 F. Supp. at 151 (in analyzing sufficiency of personal involvement, knowledge of supervisor and extent to which he encourages or acquiesces in misconduct are factors). Undoubtedly, sufficient personal involvement by these defendants turns on whether they at least should have known that their failure to take action would result in injury to the plaintiff. *Cf. Parratt v. Taylor*, 101 S. Ct. at 913 n. 3 (indicating that lower court could only have found personal participation by defendants if it had found at least negligence contributing to the constitutional deprivation). In the context of this case, however, an independent inquiry into state of mind for causation purposes is unnecessary. The defendants have all raised the qualified immunity defense. *See Scheuer v. Rhodes*, 416 U. S. 232, 238-39 (1974). Since analysis of the good faith defense raises overlapping questions concerning the mental state

of these defendants, the court will address the question in connection with the good faith defense.

III. THE DEFENDANTS' STATES OF MIND

State officers acting pursuant to their official capacities may limit their potential liability by raising a qualified immunity defense. The availability of that defense depends upon whether they took their action in good faith. Such a protection from liability becomes necessary to guard against the injustice of subjecting an official to an award of damages when, in good faith, he exercises discretion conferred upon him by his position, and to avoid the danger that the threat of liability will render officials too timid and indecisive to exercise their duties diligently. *Scheuer v. Rhodes,* 416 U. S. at 240. To a significant degree, the availability of the defense depends upon the clarity of the constitutional right infringed.

The defense has two separate strands. If the relevant constitutional right was clearly established at the time of the violation, a public official may be liable if "he knew or reasonably should have known that the action he took within his sphere of official responsibility would violate the constitutional rights" of the plaintiff. *Wood v. Strickland,* 420 U. S. 308, 322 (1975); *accord, O'Connor v. Donaldson,* 422 U. S. at 577. Absent a clearly established constitutional right, a public official need only respond in damages under § 1983 if "he took the action with a malicious intention to cause a deprivation of constitutional rights or other injury . . . ." *Wood v. Strickland,* 420 U. S. at 322.

Review of the present case requires consideration of the latter strand of the test for good faith immunity be-

cause the Court of Appeals for this circuit appears to have held, in an analogous context, that the constitutional right in question cannot be regarded as clearly established during most of plaintiff's commitment. *Scott v. Plante,* 641 F. 2d 117, 128 (3d Cir. 1981); *Reese v. Nelson,* 598 F. 2d 822, 826 (3d Cir. 1979). In any event, under the evidence in this case, I find that defendants did not know, or reasonably should have known, that their failure to supervise and oversee diagnostic and treatment procedures at Farview, would violate a clearly established constitutional right of plaintiff to treatment, including a specific drug regimen which, under the evidence, would have improved his mental condition sufficiently to require his release. Credible evidence established that those in charge of mental health facilities were, at least, uncertain as to their full responsibilities under existing law, much less their obligations under the United States Constitution. For example, Dr. Heller claimed that prior to 1973, "[p]eople were sent [to Farview] 'until further order of the court' to tremulous people called physicians who had no idea as to how to relate to the justice system." 4 trial transcript at 93. Since the law does not charge public officials with predicting the future course of constitutional law, *Procunier v. Navarette,* 434 U. S. 558, 563 (1978), these defendants can avoid liability by showing the absence of malice. *See Skehan v. Board of Trustees,* 538 F. 2d 53 (3d Cir. 1976) (defendant bears burden of proving good faith). "Malicious intention" in the context of the good faith defense contemplates a high degree of understanding by the actor of the consequences of his action. *See Procunier v. Navarette,* 434 U. S. at 566. The court in *Navarette* cited the Restatement (Second) of Torts, § 8A (1965) to illustrate the state of mind contemplated. *Id.* That section reads:

Section 8A Intent

> The word "intent" is used throughout the Restatement to denote that the actor desires to cause the consequences of his act, or that he believed that the consequences are substantially certain to result from it.

Id.

The definition requires fine-line drawing. As the comment to § 8A states, in part:

> Intent is not, however, limited to consequences which are desired. If the actor knows that the consequences are certain, or substantially certain, to result from his act, and still goes ahead, he is treated by the law as if he had in fact desired to produce the result. As the probability that the consequences will follow decreases, and becomes less than substantially certain, the actor's conduct loses the character of intent, and becomes mere recklessness, as defined in § 500. As the probability decreases further, and amounts only to a risk that the result will follow, it becomes ordinary negligence, as defined in § 282.

Id., 8A Comment B.

Although the defendants ultimately bear the burden of proving their good faith, the court believes that plaintiff's case must first raise a sufficiently substantial question of malice to trigger the defendant's burden. In *Navarette*, the Supreme Court indicated that the malicious intent strand of the good faith defense was not implicated by a cause of action based solely on negligence. 434 U. S. at 566. Accordingly, the court must examine the nature of plaintiff's evidence against each of the remaining defendants to determine whether the particular defendant sustained his burden of disproving malice.[9]

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[9]The court notes that *Skehan* appears to place the burden of proof for the good faith defense on the defendant without

(Continued on following page)

Turning first to defendant Fitzgerald, the court does not believe that any issue of malice has been raised by the evidence. Mr. Fitzgerald's duties consisted primarily of supplying a variety of social services to the Farview patients. As part of these duties, Mr. Fitzgerald undertook review of the status of patient commitments and the need for reports to the committing courts. The principal facts from which liability against Mr. Fitzgerald can be established are that his duties included an obligation to review commitments of patients like plaintiff, and that Mr. Fitzgerald in fact never reviewed plaintiff's commitment. These facts might raise inferences that Mr. Fitzgerald failed to review patient files carefully, but the court finds no basis even to suspect, much less find, that any deviation from his duties was so gross that he might be

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qualification. 538 F. 2d at 61-62. *Procunier v. Navarette*, however, appears to hold that the malicious intent strand of the good faith defense is not implicated by a cause of action based on negligent deprivation of constitutional rights. 434 U. S. at 567. The *Navarette* court observed:

> The third claim for relief with which we are concerned here, however, charges negligent conduct which normally implies that although the actor has subjected the plaintiff to unreasonable risk, he did not intend the harm or injury that in fact resulted . . . the prison officers were charged with negligent and inadvertent interference with the mail and the supervisory personnel with negligent failure to provide proper training. To the extent that malicious intent to harm is a ground for denying immunity, *that consideration is clearly not implicated by the negligence claim now before us.*

Id. (emphasis supplied)

Thus the court believes that *Skehan* should be read in light of *Navarette* to require a defendant to bear the burden of proof only when the nature of plaintiff's claim "implicates" considerations of malicious intent.

charged with the knowledge that his conduct of review of patient files was substantially certain to harm plaintiff or other patients situated similarly to plaintiff. Accordingly, the court concludes that whatever contribution Mr. Fitzgerald made to the continuation of plaintiff's unconstitutional confinement, he conducted himself in subjective good faith.

Dr. Shovlin, on the other hand, was an official with whom principal responsibility lay for providing care and treatment to the patients at Farview. He acted in this capacity from 1949 until 1974. The plaintiff has established that the institution operated without any systematic procedure for reviewing the diagnosis, need for care and treatment, or appropriateness of long-term commitment to Farview throughout Dr. Shovlin's tenure. The plaintiff has adequately proven that Dr. Shovlin would have been aware of this deficiency. Inferentially at least, the plaintiff demonstrated thereby that Dr. Shovlin would have known that there may have been patients who could have been released either immediately or after treatment but remained unattended at Farview indefinitely. Dr. Shovlin was stationed at Farview, in close proximity to the very subordinates who were failing to discharge the statutory duty to provide psychiatric treatment and evaluation.

The court believes that this record shows a departure from the proper exercise of duties by Dr. Shovlin that goes beyond mere negligence. As several courts have noted, a fine line separates the concepts of gross negligence from the sort of deliberate indifference that would implicate issues of malice. *See Doe v. New York City Department of Social Services*, 649 F. 2d at 143; *Owens v. Haas*, 601 F. 2d at 1246, 1247. Proof of indifference to present legal

duty and utter forgetfulness of legal obligations creates a "strong presumption of deliberate indifference." *Doe v. New York City Department of Social Services*, 649 F. 2d at 143 n. 8. The court is satisfied that the plaintiff offered sufficient evidence to raise the presumption that Dr. Shovlin exhibited deliberate indifference to the conditions under which plaintiff and other patients at Farview were being confined. Such a presumption suffices to place upon Dr. Shovlin the burden of demonstrating his good faith.

Plaintiff's evidence against Dr. Willis also suffices to impose an obligation upon him to disprove malicious intention. From approximately 1959, Dr. Willis directed clinical programs at Farview. As with Dr. Shovlin, plaintiff's evidence shows that Dr. Willis was aware of the lack of any procedure for identifying all patients at Farview who needed care, treatment, or further institutionalization. The court infers that Dr. Willis knew that the lack of such a procedure would leave virtually all decisions concerning diagnosis and treatment to ward physicians. Furthermore, Dr. McGuire indicated that, on the basis of his review of patient files, plaintiff's case was not unique at Farview. Some patients could remain at the institution pursuant to invalid commitments and without psychiatric attention for years.

Dr. Willis held a supervisory position that implicated the most direct control and authority over the clinicians who were actually on the wards. On the basis of that control and authority, the court believes that Dr. Willis was aware of the shortcomings of the staff. No person at the

hospital occupied a position in which the deficiencies could have been clearer.[10]

Plaintiff's case, the court finds, raised a substantial issue concerning whether Dr. Willis' derelictions were so extreme as to warrant treating them as taken with substantial certainty that patients such as the plaintiff would remain indefiniely at Farview without so much as an evaluation of the propriety of their incarceration under Pennsylvania Mental Health law or their need to receive psychiatric treatment that might justify under Pennsylvania law, their very presence at Farview. Drs. Shovlin and Willis both testified to their subjective good intentions. Each, through his own testimony, attempted to portray his administrative decisions as reasonable courses of action in light of the conditions at Farview. Each outlined the range of his duties at Farview and the manner in which he allocated his time and energies among those duties.

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[10]The mere fact that liability is predicated on a failure to act does not prevent the finding of malicious intent within the meaning of *Navarette*. In Bogard v. Cook, 586 F. 2d at 412, the United States Court of Appeals for the Fifth Circuit opined:

> [W]e read the malicious intent prong of the official immunity defense to require that an official either actually intended to do harm to the plaintiff, or took an action which, although not intended to do harm, was so likely to produce injury that the harm can be characterized as substantially certain to result. The spirit of the rule reaches nonfeasance as well as misfeasance. It does not insulate an official who, although not possessed of any actual malice or intent to do harm is so derelict in his duties that he must be treated as if he in fact desired the harmful results of his inaction. At the same time, however, the test requires that a plaintiff show that the official's action, although labeled as "reckless" or "grossly negligent," falls on the actual intent side of those terms, rather than on the side of simple negligence.
>
> *Id.*

In analyzing the sufficiency of their evidence of good faith, the court notes the narrowness of the issue presented. Unless a defendant wielded authority so as "to inflict harm for reasons unrelated to the performance of [his] duties," *Reese v. Nelson*, 598 F. 2d at 828, the court should not reject the asserted immunity. Moreover, Drs. Shovlin and Willis are entitled to benefit of a presumption that they conducted themselves in good faith. A court should assume that official discretion has been exercised soundly absent proof to the contrary. *Neal v. Secretary of the Navy*, 639 F. 2d 1029, 1037-38 (3d Cir. 1981); *Kephart v. Richardson*, 505 F. 2d 1087, 1090 (3d Cir. 1975).

No one challenged the fact that the Commonwealth did not supply sufficient professional personnel and related support material to make Farview a mental hospital in fact as well as in name. It was more of a custodial facility and apparently was intended to be little more by the legislature. Throughout the pertinent period for purposes of this lawsuit, it was overcrowded and understaffed. Dr. Heller, Clinical Professor of Psychiatry at Temple University and Director of Forensic Psychiatry for the Pennsylvania Office of Mental Health, was an informative and generally disinterested witness who had substantial familiarity with the conditions at Farview from 1960, when he served as Director of Psychiatry at the Eastern Pennsylvania Penitentiary, through the 1970's when he became associated with the Pennsylvania Department of Mental Health. He came down hard on the State officials who constructed Farview in an area "remote from professional [and] academic sources" to which were sent the worst cases, including the most difficult assaultive patients, "from all over the Commonwealth by the Correctional system,

the criminal justice system, and the public sector mental health system." He portrayed it as "a very clean, well organized, tightly run institution where behavioral outbursts were not tolerated" although "you can't go from one ward to another . . . without being accompanied by one or two guards, even if you're a nurse who works there." 4 trial transcript at 45, 95. He charged that it was staffed with "retirement oriented" general practitioners who were "fraudulently labeled as psychiatrists when indeed they were not." 4 trial transcript at 49. According to Dr. Heller, "Farview hospital was not an institution that the Commonwealth has any right to be proud of" but insisted that Drs. Shovlin and Willis did the best they could and that they "are not the villians, these are the fall guys." 4 trial transcript at 136, 143. As to the support provided to the facility he stated

> ". . . there were no psychiatrists at Farview State Hospital. I wouldn't have worked there on a bet. And I was offered the Superintendency at Farview State Hospital and said, no thank you. I don't think that any reasonable psychiatrist who knows what goes on there, and the lack of support that the Commonwealth provides Farview would take the job. The only people we can recruit are the kinds of people that are here and we leave them twisting in the wind." 4 trial transcript at 81.

His description of the Farview facility, with a large patient population ranging from physically dangerous psychotics to relatively passive schizophrenics such as Laurence Stuebig, provides an appropriate backdrop for evaluating the issue of malicious intention. It was in this environment that Drs. Shovlin and Willis pronounced and executed treatment policies. As psychiatrists and administrators, they should have realized that, even under such

burdensome conditions, their policies for identifying and treating patients under their care, and in some instances returning them to the committing courts or otherwise releasing them, were inadequate. Neither physician knew plaintiff nor remembered ever reviewing plaintiff's file. They admitted that there was no procedure for periodic review by staff of patients' records although allegedly ward physicians were required every six months to make comprehensive notes as to the mental and physical condition of each patient. Both claimed that, because of the overpopulation of patients, it devolved upon ward physicians and other staff members to ferret out patients who were not receiving adequate treatment or who had improved to the point that consideration should be given to transferring them from Farview. Dr. Shovlin became so immersed in administrative duties, consuming 85-90% of his time, that he delegated most treatment decisions to Dr. Willis. Dr. Willis testified that staff saw approximately 15 patients a week but that ward physicians had the primary responsibility to evaluate the patients under their care.

The plaintiff attempted to offer evidence of Dr. Willis' malice through the testimony of Dr. McGuire. Dr. McGuire testified that Dr. Willis regarded Farview's patients as "pests and fakers," and that Dr. Willis believed that the institution should not interrupt a "stable psychosis." Dr. Willis denied making the first remark and explained that the second remark was lifted out of its appropriate context. The court finds Dr. Willis' answer to these accusations to be more credible.

The court must note that Dr. McGuire's testimony should be weighed in light of his personal conflicts with

Dr. Willis, and his desire to defend his own record as Superintendent at Farview. Clearly, Drs. Willis and McGuire had radically different philosophies concerning patient care at Farview. While Dr. Willis allegedly believed that the institution should use its limited treatment resources on patients who would benefit from them most, Dr. McGuire believed that the institution should reach all its patients to the extent that resources would permit. The record shows that this difference in philosophies produced heated disagreement.

Dr. Willis testified that the "stable psychosis" remark stemmed from this disagreement. Dr. McGuire, according to Dr. Willis, pressed for devoting more treatment resources to geriatric patients who had been institutionalized for extended periods. Dr. Willis, on the other hand, believed that drug treatment or other active therapy should not be forced on such patients merely for the sake of ensuring that all the patients at the institution were treated. In the context of an overcrowded, understaffed institution, Dr. Willis' view of such treatment decisions cannot be characterized as malicious.

Similiarly, the court finds difficulty in attaching great significance to Dr. McGuire's testimony concerning the alleged "pests and fakers" remark. While the court places some reliance on Dr. McGuire's factual account of conditions at the hospital, the court is unprepared to allow substantial liability to turn upon controverted evidence of a witness who bears antagonism toward a defendant. From my observation of Dr. McGuire, his reaction to questions concerning Dr. Willis' performance reflected a personal bias and eroded the reliability of such testimony.

CONCLUSION

The plight of plaintiff underscores the fact that someone wasn't performing properly either in setting up treatment standards and policy or in carrying out established policy. No award or expression of sympathy can recover the lost years for him. I am satisfied that the policy promulgated at Farview was inadequate not only in failing to provide for a periodic automatic review of the condition of each patient, but in insuring that staff understood, and were carrying out, their evaluative duties. But while such inadequacies and derelictions may, at least, constitute negligence, the question here is whether the performances of Drs. Shovlin and Willis were so egregious as to justify a finding that they maliciously intended to cause harm to the plaintiff and those similarly situated. Such a finding does not require that they possess actual malice or intent to harm, but does require conduct greater than recklessness. *See* Restatement (Second) of Torts, § 8A (1965). While Drs. Shovlin and Willis should have known that the policies and procedures at Farview were inadequate, I am satisfied that they did not know, with substantial certainty, that plaintiff was not receiving such evaluation and treatment as would be necessary to justify his continued confinement at Farview. Their derelictions were not so extreme as to warrant a conclusion that they in fact desired the harmful results of their inaction. *See Bogard v. Cook,* 586 F. 2d at 412. Neither man appeared to the court to be maliciously motivated or to possess any ill will toward plaintiff or the patient population. The advantage of hindsight scarcely needs elaboration but it appears that their administrative failures as hereinbefore enumerated had disastrous consequences to Laurence Stuebig. He

spent his long years at Farview virtually unnoticed and his plight can be laid firmly at the door of the Commonwealth and its employees at Farview. However, inasmuch as the Commonwealth is entirely immune from liability under the Civil Rights Act, plaintiff must seek recovery from the individual employees he believes were responsible for his constitutional deprivations. As previously mentioned, if the standard of liability were one of negligence, then plaintiff would clearly be entitled to relief. But the standard fashioned by the United States Supreme Court is much more demanding before one can successfully press a damage claim under 42 U. S. C. § 1983. In a claim of constitutional deprivation, a public official is entitled to immunity from damages for his misconduct if he acted in good faith. The actor satisfies that good faith requirement if he can show that the constitutional right which was transgressed was not clearly established at the time of the violation and that he did not maliciously intend to deprive the plaintiff of his constitutional right or to cause him other injury. I have found that plaintiff's constitutional right to active psychiatric treatment, including an appropriate drug regimen, was not clearly established during the pertinent time period and that neither Dr. Shovlin nor Dr. Willis bore any malicious intention or ill will toward plaintiff or any patients at Farview similarly situated. Such findings require the entry of judgment for the defendants.

/s/ William J. Nealon
Chief Judge, Middle District
of Pennsylvania

Dated: December 31, 1981

ORDER

Now, this 31st day of December 1981, in accordance with the memorandum this day filed, it is ordered, that judgment be entered for all defendants.

/s/ William J. Nealon
Chief Judge, Middle District
of Pennsylvania

Civil No. 76-1165

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

LAURENCE STUEBIG, a/k/a LAWRENCE STUEBIG
by his Guardian, MARIA CAROLE BECKMAN,

Plaintiff,

vs.

ROBERT J. HAMMEL, et al.,

Defendants.

MEMORANDUM AND ORDER

(Filed October 29, 1982)

Laurence Stuebig, a former patient at the Farview State Hospital for the Criminally Insane, Instituted the present action for damages under the Civil Rights Act of 1871, 42 U. S. C. § 1983 (1976). Six present and former employees at Farview allegedly deprived plaintiff of his Fourteenth Amendment rights by failing either to provide treatment for his schizophrenia or secure his release. The court held four days of evidentiary hearings without a jury

in February of 1980.[1] The proceedings culminated in a Memorandum and Order dated December 31, 1981 in which this court ordered entry of judgment in favor of all the defendants. Pursuant to that Order, judgment was entered on January 4, 1982. Presently before this court are plaintiff's alternative motions under Fed. R. Civ. P. 50(b) and 59. Since this matter was tried without a jury, the court will construe plaintiff's motion under 50(b) as properly arising under Fed. R. Civ. P. 52(b).

The unfortunate facts of this case are set forth at length in the court's Memorandum and Order of December 31 and require little elaboration. Suffice it to say that plaintiff, a harmless schizophrenic, was involuntarily committed to Farview in January of 1941 and languished there, largely without psychiatric treatment or evaluation, until his release in December of 1975. Cumulatively, the six defendants did nothing of therapeutic value for plaintiff's mental disorder, although a drug treatment regimen would probably have enabled Farview officials to release plaintiff at almost anytime after 1965. Nevertheless, as the court previously noted, this civil rights action focuses not upon the fairness and humanity of the treatment plaintiff received at the hands of the Commonwealth of Pennsylvania, but rather on the propriety of assessing damages against the six individual agents of the Commonwealth who, to a greater or lesser extent, had contact

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[1]In November of 1980, the court extended an opportunity to file briefs addressing Romeo v. Youngberg, 644 F. 2d 147 (3d Cir. 1980), which the Supreme Court recently vacated, *see* 102 S. Ct. 2452 (1982). The parties filed additional arguments in December of 1980. The record closed on December 24, 1980.

with plaintiff during his thirty-odd years of incarceration at Farview.

A brief review of the court's previous conclusions provides an appropriate starting point for disposition of these motions. First, the record in this case amply established that the Commonwealth exceeded its authority under the Fourteenth Amendment due process clause in its treatment of plaintiff. Although plaintiff represented a danger neither to himself nor to others between 1941 and the late 1960's, plaintiff remained at Farview throughout that period. The only legitimate basis for continuing this confinement would have been plaintiff's need for treatment of his schizophrenia.

Until approximately 1956, no suitable treatment was available and, thereafter, no such treatment was administered. Second, the court concluded that plaintiff's evidence failed to establish the personal involvement of three of the named defendants adequately: Dr. Horan, Dr. Powell and Francis Truman, former captain of Farview's guards. Third, the court found that plaintiff's evidence did not raise a sufficiently substantial issue of intent to prevent judgment for defendant Fitzgerald as a matter of law on the basis of a good faith immunity from damages. Finally, the court entered judgment for Dr. Willis, Farview's Clinical Director, and Dr. Shovlin, Farview's Superintendent, because each had acted in subjective good faith. Since plaintiff's constitutional rights were not clearly established at the time of the offending conduct, the court determined that this good faith sufficed to immunize them from an award of damages.

Plaintiff submitted thirteen points in support of his contention that the court's judgment is erroneous. Re-

duced to their essence, these points are as follows: (1) sufficient evidence supports a finding of personal involvement by defendants Horan, Powell and Truman; (2) the court improperly shifted to plaintiff the burden of disproving the good faith of defendants Willis, Shovlin and Fitzgerald; (3) the court's conclusion that defendants Willis and Shovlin conducted themselves in subjective good faith runs contrary to the evidence and the law; and (4) the court should have found liability on the part of all of the defendants. Plaintiff supported the contentions with a Memorandum of Law. No specific request for amended or supplemental findings of fact, however, accompanied these motions.[2]

While plaintiff's motions were pending, the United States Supreme Court issued an opinion in the case of *Harlow v. Fitzgerald*, 102 S. Ct. 2727 (1982). Effectively, the court narrowed the definition of the qualified immunity so as to eliminate inquiry into the subjective intent of public officials absent a violation of clearly established law. The court stated:

> We therefore hold that government officials performing discretionary functions are shielded from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitu-

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[2]Although a motion under Rule 52(b) primarily provides a party an opportunity to obtain clarification of the factual issues determined by the trial court, see 9 C. Wright & A. Miller, Federal Practice and Procedure, § 2581 (1971), plaintiff neither challenges any particular fact finding nor protests that the factual basis for the court's decision is unclear. The defendants, who filed an opposing brief, have likewise set forth neither additional nor contrary factual findings. Like the parties, the court will proceed in discussing these issues on the basis of the facts as developed in the December 31st Memorandum.

tional rights of which a reasonable person would have known.

Id. at 2738.

Although Harlow dealt with the scope of qualified immunity for Federal executive officials, the Court left no doubt that its holding applied equally to actions under the Civil Rights Act of 1871, 42 U. S. C. § 1983 (1976). 102 S. Ct. at 2738 n. 30.

On June 29, 1982, the court extended to the parties an opportunity to address the application of *Harlow* to this action. Defendants have not availed themselves of the opportunity. Plaintiff, on the other hand, filed a brief on August 2, 1982. Having considered the matters raised both in the original papers and the supplemental brief, plaintiff's post-trial motion is hereby denied for the reasons that follows.

I. PERSONAL INVOLVEMENT

As this court indicated in its earlier Memorandum, plaintiff bears the burden of demonstrating an "affirmative link" between the conduct of each defendant and the deprivation of constitutional rights. *Monell v. New York Department of Social Services,* 436 U. S. 568, 593 (1978); *Rizzo v. Goode,* 423 U. S. 362, 371-72 (1975). While such a showing of personal involvement does not necessarily require affirmative acts by a defendant, inaction forms the basis of personal involvement only when the defendant bore some responsibility to take action. *E.g., Johnson v. Duffy,* 588 F. 2d 740, 743 (9th Cir. 1978); *see Stuebig v. Hammel,* No. 76-1165, slip op. at 41-43 (M. D. Pa., December 31, 1981). Since the nature of plaintiff's allegations against all the defendants rested upon a theory

of deprivation of rights through neglect, the court conducted its evaluation of the personal involvement of each defendant on the premise that the defendant must have borne an obligation to provide care or to supervise the provision of care before his failure to act would form the equivalent of personal involvement.[3]

Plaintiff does not seriously challenge this premise. Instead, plaintiff's argument appears to rest on the belief that this record would establish the existence of a duty on the part of defendants Horan, Powell and Truman to provide the psychiatric evaluation and treatment that plaintiff never received. In none of the documents filed in support of these motions, however, does plaintiff refer to any evidence beyond that relied upon by the court in its earlier Memorandum to sustain a finding of personal involvement. Having reviewed the record, the court concludes that the evidence would not warrant any change in the earlier findings.

A. Doctor Horan

The court's finding that Dr. Horan's conduct did not rise to the level of "personal involvement" stemmed from several factual findings. Dr. Horan, who worked at Farview between 1967 and 1977, was the ward physician on the surgical and medical wards at Farview. *See Stuebig v. Hammel*, slip op. at 7 (Findings of Fact 20 & 21). Dur-

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[3]As this court noted in the December 31st Memorandum, a duty to take action may arise from a variety of sources, including state or local law. I found a generalized duty to provide psychiatric care under Pennsylvania's mental health statute. The existence of this generalized duty, however, does not dispose of the separate question of the extent to which each defendant bore responsibility for discharging the statutory duty. Stuebig v. Hammel, slip op. at 41-48.

ing the 1960's plaintiff spent only three brief periods on the surgical and medical wards; the longest period was for approximately three weeks. *Id.* at 25-26 (Finding of Fact 87). Thus, plaintiff's proof concerning the personal involvement of Dr. Horan, at least during the 1960's would require a conclusion that a physician rendering medical treatment on three occasions over several years involved himself in the wrongful incarceration of a patient housed at a maximum security mental hospital by failing either to evaluate the psychiatric problems of that patient or to provide appropriate treatment.

The record demonstrated that the duty to provide that treatment fell upon the physician supervising the ward on which a patient lived. *Id.* at 15 (Finding of Fact 48); *Id.* at 18 (Finding of Fact 57). Physicians on medical wards bore responsibility primarily for providing medical as distinct from psychiatric treatment. No direct or circumstantial evidence in this record pointed to the conclusion that Dr. Horan knew of, or acquiesced in, any refusal by plaintiff's supervising ward physician to evaluate plaintiff psychiatrically or to provide appropriate treatment. The court viewed this tangential involvement with plaintiff as too attenuated to satisfy the requirement of affirmatively linking Dr. Horan to unconstitutional conduct.

A review of the plaintiff's proposed fact findings reveals that, before judgment was entered in this case, plaintiff never seriously contended that liability could flow from Dr. Horan's conduct in the 1960's. *See* Plaintiff's Proposed Findings of Fact at 4, 18 (Proposed Findings 15, 35). Instead, plaintiff predicated his theory of liability against Dr. Horan on events occurring between

1970 and 1975 when plaintiff was housed on the surgical and medical wards for more extensive periods. *See* Plaintiff's Proposed Findings of Fact and Conclusions of Law at 4 (Proposed Findings 15). After 1969, however, plaintiff could not have been treated with anti-psychotic drugs safely. *See Stuebig v. Hammel,* slip op. at 28 (Finding of Fact 92). Moreover, Alzheimer's Disease and chronic institutionalization had progressively disabled plaintiff throughout the late 1960's. *Id.* at 4 (Findings of Fact 10 and 11).[4] The constitutional deprivation that the court found stemmed from failure to evaluate and treat plaintiff for his psychiatric disorder. The court concluded that Dr. Horan's contact with plaintiff, which occurred when treatment would no longer have benefitted plaintiff, provided

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[4]No liability could attach for Dr. Horan's conduct in the 1970's. First, Dr. Horan still did not bear the primary responsibility for evaluating plaintiff psychiatrically. At any rate, significant changes in plaintiff's condition rendered him no longer susceptible to treatment through an anti-psychotic drug regimen.

Whereas plaintiff, in the mid-1950's, was in his fifties, healthy and suffering only from a mild to moderate schizophrenia, he was, in 1970, over sixty years of age, debilitated by chronic institutionalization, and afflicted with Alzheimer's Disease, diabetes and circulatory ailments. An evaluation of plaintiff in the 1970's, which would have been Dr. Horan's first opportunity would not have dictated an aggressive treatment program; plaintiff could no longer care for himself, and no therapy modality had promise for improving his condition. *See* Stuebig v. Hammel, slip op. at 2, 4, 28 (Findings of Fact 1, 9-10, 91-92).

In effect, Dr. Horan's involvement with plaintiff occurred after the damage had been done. Whatever harm the inadequacies of the institution had inflicted before 1970, that harm is not chargeable to Dr. Horan. The ward physicians who had daily contact with plaintiff during the 1950's and 1960's have not been identified or joined as parties to this action. Their derelictions may not be attributed vicariously to Dr. Horan.

no substantial basis for a showing of personal involvement in the deprivation of treatment and evaluation. Plaintiff claims neither contrary authority nor additional evidence which counsels a different conclusion. Accordingly, the judgment in favor of Dr. Horan will not be modified.

B. Dr. Powell

Like Dr. Horan, Dr. Powell had only fleeting contact with the plaintiff; plaintiff spent a total of four days on a ward supervised by Dr. Powell during the 1960's. *See Stuebig v. Hammel,* slip op. at 26 (Finding of Fact 86). In addition, plaintiff saw Dr. Powell on fourteen other occasions during the 1970's. In each of these instances, uncontroverted testimony indicated that these consultations were for plaintiff's medical problems. Trial transcript at 26. Nevertheless, plaintiff contends that this evidence sufficed to establish personal involvement on Dr. Powell's part.

Again, no further authority or evidence has been advanced to support the contention that the court's previous conclusion was erroneous on the basis of the facts found. Had plaintiff shown that Dr. Powell assumed ward physician responsibilities over plaintiff for some extended period of time when plaintiff could have improved his condition as a result of treatment, an inference of personal involvement in the deprivation of plaintiff's rights would have arisen. The court, however, cannot endorse the proposition that even the most casual contact with a mentally ill patient warrants a finding of personal involvement in detention rendered unconstitutional by the failure of others to provide psychiatric care. Thus, the court reaffirms its conclusion that no sufficient case of personal involvement was made against Dr. Powell.

C. Francis Truman

Mr. Truman worked as a guard at Farview for over twenty years. The court has previously found that insufficient evidence of personal involvement was adduced at trial. The present motion asserts that the court should now make such a finding on the basis of Mr. Truman's failure to initiate any review of the plaintiff's commitment. Not a scintilla of evidence supports the proposition that Mr. Truman ever bore a duty to institute such a review concerning plaintiff. The sole finding proposed by plaintiff to this court concerning the liability and involvement of Mr. Truman reads:

> The defendant Francis Truman was employed at Farview State Hospital as a guard in 1954, was promoted to Supervisor of Guards in 1961 and served as Captain of Guards from 1974 to 1977. He worked as a guard on N Ward in the 1950's. The plaintiff was a patient confined to N Ward from February 22, 1941 until January 4, 1966 when N Ward was demolished. N. T. 3-159 to -160, 167; Ex. P-2, pp. 7A-12.
>
> Plaintiff's Proposed Finding of Fact at 4.

The evidentiary foundation for this requested finding concerning Mr. Truman's involvement stems from the following examination of Mr. Truman:

> Q. Did you ever work in N Ward?
>
> A. N Ward?
>
> Q. Yes.
>
> A. Oh, a few times back in the 1950's maybe when I first started there. I was a floater when I first started.

N.T. 3-167.[5]

The court does not view the defendant's admission that he may occasionally have worked on the same ward where the plaintiff resided as a sufficient basis to find personal involvement. The court's findings reflect that some responsibility for identifying patients as candidates for treatment fell upon guards. *Stuebig v. Hammel*, slip op. at 16, 18, 21 (Findings of Fact 50, 58, 59, 69). Working on a ward "a few times," however, hardly charges a guard with a duty to ferret out and evaluate each and every treatable patient on that ward. Neither does the record reflect that supervisory treatment functions fell either upon guard supervisors or upon the captain of the guards.

In short, neither Mr. Truman's direct nor supervisory duties ever encompassed the provision of psychiatric care to the plaintiff. Certainly, Mr. Truman did nothing of therapeutic value for plaintiff; that is undisputed. Lacking from plaintiff's proof, however, is the

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[5]The remaining references to the record cited by plaintiff describe Mr. Truman's duties and in no way implicate him personally in the institution's treatment of plaintiff. Again, the evidence falls far short of establishing involvement of either a direct or supervisory nature. Farview's patient population varied between eight hundred and fourteen hundred during plaintiff's confinement. The treatment statuses of these patients could hardly have been within the personal knowledge of a guard supervisor.

The record demonstrates no contact between Mr. Truman and plaintiff beyond the incidental contact that might be inferred from the fact that Mr. Truman may have been a "floater" on plaintiff's ward for brief periods. Plaintiff had ample opportunity to elucidate any treatment responsibilities that supervisory guards may have had during the testimony of Mr. Truman or Farview's administrators. No such testimony was elicited. The onus to demonstrate a causal connection is upon the plaintiff; insufficient evidence of such a connection appears in this record.

slightest evidence that Mr. Truman had any knowledge of plaintiff's existence, much less his treatment needs, or that he neglected some obligation to ascertain whether plaintiff needed treatment. To hold that Mr. Truman was personally involved in the deprivation of plaintiff's rights would be tantamount to holding that mere proof that someone worked at the institution at roughly the same time as plaintiff was confined militated in favor of a finding of personal involvement. The court does not endorse that proposition, and declines to alter the judgment entered in Mr. Truman's favor.

II. QUALIFIED IMMUNITY

The remaining contentions focus on application of the qualified immunity from damages to which these defendants, as public officials exercising discretionary authority,[6] are entitled. First, plaintiff asserts that the previous judgment resulted from misallocation of the burden of proof. Second, plaintiff argues that the record establishes these defendants' malicious intention to harm him.

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[6]Plaintiff has, at various points, advanced the proposition that the defendants acted without discretionary authority. At least one circuit has recognized that some conduct by public officials falls so far outside the scope of their lawful duties that immunity does not attach. Barker v. Norman, 651 F. 2d 1107, 1121 n. 18 (5th Cir. 1931). Even assuming that the courts of this circuit adopted such a rule, forfeiture of the immunity would only result from the most flagrant abuses of authority. *Id.* (citing Harper v. Merckle, 638 F. 2d 848 (5th Cir. 1981)).

This factual record does not present an instance of flagrant abuse of authority. The defendants who were personally involved in plaintiff's incarceration supervised and administered Farview. The injury to plaintiff resulted from deficiencies in the treatment and diagnostic programs that the defendants initiated rather than from an unlawful wielding of power derived from their duties as administrators of the hospital. *See infra* at 14.

Finally, in plaintiff's view, the subsequent changes in immunity law that *Harlow v. Fitzgerald* announced should not foreclose a judgment against these defendants. The court rejects each of these arguments.

1. The Burden of Proof

Plaintiff's first argument stems from the court's analysis of evidence of malice on the part of three defendants, Dr. Shovlin, Dr. Willis and Mr. Fitzgerald. Having concluded that immunity would shield the defendants absent a malicious intention to harm plaintiff, the court sifted plaintiff's evidence to determine whether any substantial issue of intent had been raised. In requiring any preliminary evidentiary showing plaintiff contends the court impermissibly shifted the burden of proof.

At the time that this action was tried, immunity law called for application of a double-tiered test; one tier consisting of an objective test, the other tier consisting of a subjective test. To deter public officials from ignoring the basic constitutional rights of those affected by their actions, the official lost immunity under the objective test if he violated clearly established constitutional law of which that official should have known. To protect a public official from suffering consequences of unforeseeable changes in constitutional interpretation, the subjective test permitted liability only if the official either knew of the unconstitutionality of his actions or maliciously intended to harm the plaintiff. *Wood v. Strickland*, 420 U.S. 308, 321-22 (1975).

This qualified immunity is an affirmative defense. The defendant must plead the defense, *Gomez v. Toledo*, 446

U. S. 625, 640-41 (1980), and, in this circuit, must persuade the court of his "good faith."[7] *E. g., Skehan v. Board of Trustees,* 538 F. 2d 53, 61-62 (3d Cir. 1976). A court may not conclude that a qualified immunity protects a public official absent evidence on the record from which a finding of "good faith" may be made. *United States ex rel. Tyrrell v. Speaker,* 535 F. 2d 823, 829 (3d Cir. 1976); *Fidtler v. Rundle,* 497 F. 2d 794, 801-02 (3d Cir. 1974).

The present case raised a narrow immunity question. Having determined that a constitutional right to psychiatric treatment was not clearly established at the time that these defendants acted, and that the defendants were exercising discretion in the course of their official duties, the availability of immunity turned on the issue of malicious intention to-harm plaintiff. A reading of *Procunier v. Navarette,* 434 U. S. 555 (1978) persuaded the court that an extended inquiry into the defendants' proof of subjective good faith was unnecessary if plaintiff's evidence raised no substantial issue of deliberate misconduct.

In *Navarette,* the Supreme Court affirmed entry of summary judgment for prison officials on a civil rights claim based on allegations of negligent misconduct. As in the present case, the lack of a clearly established constitutional right triggered application of the subjective strand of the immunity. The court noted that "[t]o the extent

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[7] In this context, of course, "good faith" is a term of art. Until *Harlow,* the meaning of good faith varied depending upon whether the objective or subjective strand of the defense applied. See Wood v. Strickland, 420 U. S. at 321-22 ("good faith denotes not only a sincere belief in the lawfulness of an action but also reasonable grounds for believing that action comports with 'basic' unquestioned constitutional rights.").

that a malicious intent to harm is a ground for denying immunity, that consideration is clearly not implicated by the negligence claim now before us." *Id.* at 566.[8]

Similarly, this court found that a defendant who had established entitlement to the protection of the subjective test for immunity should not be put to his proof of good faith without evidence in the record suggesting that the misconduct charged was not merely inadvertent or negligent. In the court's view, the evidence implicating defendants Shovlin and Willis would require that they affirmatively show their good faith. The record concerning Mr. Fitzgerald, on the other hand, negated even the inference of deliberate misconduct.

Mr. Fitzgerald's involvement with plaintiff's incarceration arose from administrative duties assigned outside his principal duty, supplying patient social services. Mr. Fitzgerald handled court and third-party inquiries about the status of patient commitments. N. T. 3-197. As part of that work, Mr. Fitzgerald attempted to transfer plaintiff, among other patients, to a low-security institution. *Id.* at 187. The other institution refused to accept plain-

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[8]In *Navarette,* inmates at Soledad Prison in California brought an action for damages based upon alleged interference with the prisoners' mail. One count alleged that the supervisory officials had negligently obstructed mail delivery and failed adequately to train subordinate prison officials. 434 U. S. at 466. Without intimating whether such allegations stated a civil rights cause of action, the court approved summary disposition of the claim on immunity grounds of such negligence claims involving alleged violation of unclear constitutional law. *Id.*

tiff and Mr. Fitzgerald thereafter had no other contact with plaintiff.[9] *Id.* at 187-88.

As cross-examination revealed, this contact with plaintiff came during a period when the Social Services Department changed its function at Farview, largely through Mr. Fitzgerald's initiative. *Id.* at 191-93, 195-98. As part of this change, the Social Services Department devoted less time to clerical work concerning patient records. To the extent Mr. Fitzgerald's conduct may have adversely effected plaintiff, that effect resulted from lack of follow-up in review of plaintiff's records or lack of further attempts to have plaintiff transferred. Particularly in light of the change over in duties, the clear inference from plaintiff's own evidence is that any harm Mr. Fitzgerald may have done to plaintiff resulted from inadvertance or, at most, negligence. Thus, *Navarette,* under the circumstances, would require entry of judgment for Mr. Fitzgerald.

To the extent that plaintiff contends that this analysis shifts the burden of proof, his argument would apply solely to Mr. Fitzgerald. As the court has indicated, plaintiff's evidence did raise a substantial issue of intent with respect to Drs. Shovlin and Willis. *See Stuebig v. Hammel,* slip

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[9]As part of a program to implement the U. S. Supreme Court decision in Jackson v. Indiana, 406 U. S. 715 (1972), the Department of Welfare issued a directive to either transfer or evaluate patients committed as incompetent to stand trial under § 408 of the 1923 Mental Health Act. N. T. 3 - 203 to - 207. The attempt to transfer plaintiff, handled by Mr. Fitzgerald, resulted from this directive. Patients for whom a transfer was not possible were to await evaluation by a team of psychiatrists from outside the institution. *Id.* at 207. Having failed to obtain a transfer for plaintiff, Mr. Fitzgerald, who had no treatment or evaluation duties, would have no further involvement with plaintiff.

op. at 58-59. The burden of proof, at any rate, does not have a crucial effect on the court's evaluation of Mr. Fitzgerald's liability. Regardless of who had the burden, the record unequivocally point to the conclusion that Mr. Fitzgerald never harbored the least intention to harm plaintiff or any other patient at Farview. Accordingly, the judgment entered in Mr. Fitzgerald's favor will stand.

2. Good Faith

Plaintiff next urges the court to set aside its finding that Defendants Shovlin and Willis acted in good faith. Plaintiff points neither to any further evidence that the court may have overlooked nor to any particular factual finding that is erroneous or unclear. Rather, the brief attacks the manner in which the court interpreted the facts.

Plaintiff argues that defendants' conduct was "forbidden by every inherent standard of human decency." Document 174 at 3. Accordingly, plaintiff apparently asserts that the court should either treat the defendants as having violated a clearly established constitutional right, or, as a matter of law, find malicious intent.[10] Furthermore, plaintiff assert that these defendants could not have acted "sincerely or in the belief that they were doing right." Document 174 at 3 (quoting *Wood v. Strickland*, 420 U. S. at 321). Having reexamined the record, the court adheres

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[10]Again, plaintiff contends that the court erroneously charged plaintiff with the burden of disproving good faith. The court, however, specifically found that plaintiff's evidence implicated issues of bad faith. Stuebig v. Hammel, slip op. at 58. The risk of nonpersuasion was therefore explicitly placed upon Dr. Willis and Dr. Shovlin on the issue of good faith. *Id.* at 58-60. Accordingly, this argument lacks merit altogether.

to its previous finding that the defendants acted in subjective good faith.

In considering good faith, the court should examine the defendants' conduct in light of the circumstances under which they operated at the time of the offending conduct. *Glasser v. City of Louisville,* 518 F. 2d 899, 908 (6th Cir.), *cert. denied,* 423 U.S. 930 (1975); *Rogers v. Okin,* 478 F. Supp. 1342, 1382 (D. Mass. 1979), *affirmed in part and vacated in part on other grounds,* 634 F. 2d 650 (1st Cir. 1980). *See generally Scheuer v. Rhodes,* 416 U.S. 232, 247-48 (1974). Overpopulation and understaffing characterized the institution over the entire period during which plaintiff might have benefitted from treatment. *See Stuebig v. Hammel,* slip op. at 9-11. (Findings of Fact 26-34). Qualified psychiatric personnel were few; guards made up the overwhelming majority of Farview's staff. In Farview, the State of Pennsylvania had created a remote, inadequately-funded, custody-oriented institution to which it exiled its most unmanageable involuntary committees and the unfortunates who the Pennsylvania criminal justice system regarded as unfit to face trial.

Partly as a result of maladministration and partly as a result of sheer scarcity of resources, Farview evolved a treatment and evaluation system that required the least trained and the least motivated staff members to bear the greatest responsibility for the least attended. Two physicians with psychiatric experience supervised this system. One of them could devote about 20 percent of his time to the hospital treatment and evaluation program; the other carried a direct patient load of his own and presided over the staff conferences that provided the sole avenue for the cured or improving patient to obtain release from Far-

view. Neither conducted reviews of the entire patient population, and, as a direct result of that failure, plaintiff fell through the cracks in the system and remained unheeded and deteriorating at the institution.

Had Drs. Willis and Shovlin known of and observed plaintiff's deterioration while sitting by idly, it might be difficult to conceive of them harboring a sincere belief that they were acting properly. Neither, however, had the slightest contact with plaintiff. *Stuebig v. Hammel,* slip op. at 24 (Finding of Fact 77). Undoubtedly, either administrator could have foreseen that the nature of the psychiatric programs at Farview created a danger that some patients needing treatment or evaluation might not be identified. Moreover, their failure to institute a means of identifying such patients could only have aggravated that danger. The issue, however, was one of malicious intention or dereliction so egregious as to constitute the equivalent of malicious intention. *See Bogard v. Cook,* 586 F. 2d 399, 412 (5th Cir. 1978); *Stuebig v. Hammel,* slip op. at 55-56, 58-60.

The evidence of this case simply does not warrant a finding of actual malicious intention on the part of Dr. Willis or Dr. Shovlin.[11] The court had ample opportunity to observe each physician in the course of their lengthy testimony. Both defendants described their duties and the manner in which they allocated their time among those

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[11]As the court noted in its previous Opinion, there was direct evidence in the record concerning malice on the part of Dr. Willis. That evidence, however, is simply untrustworthy. The reasons for this conclusion are set out at length in Stuebig v. Hammel, slip op. at 62-63. No further elaboration on this point is necessary.

duties. Each defendant, in the court's opinion, exhibited a sincere belief that he proceeded reasonably in the face of conditions at Farview. That their administrative decisions permitted plaintiff to remain at Farview untreated does not demonstrate that this result was desired, intended or knowingly brought about. Nothing in the record persuades the court that their account of how they administered the institutional psychiatric program was a mere pretext for injuring plaintiff or any other patient at Farview.

A determination that Dr. Willis and Dr. Shovlin sincerely believed that they were properly discharging their duties would not necessarily preclude a finding that their course of action represented such an egregious departure from their duties as to warrant a finding of constructive malice. Nevertheless, the court concluded that no such finding was warranted and, after further consideration, adheres to that conclusion.

Dr. Willis and Dr. Shovlin were charged at Farview with administering psychiatric programs utilizing a medical staff that varied in size from three physicians to a maximum of seven. This staff would treat and evaluate a patient population that varied in size from about 800 to 1,400. *See Stuebig v. Hammel,* slip op. at 9-11 (Findings of Fact 28-34). This staff would have sufficed to carry out a drug treatment program at Farview. *Id.* at 18 (Finding of Fact 56). Farview's administrators did institute a drug treatment program; the program was conducted on an experimental basis at first and, once the staff acquired experience using particular drugs, Farview policy called for medicating patients freely. *See Id.* at 17 (Findings of Fact 53-55). If plaintiff had been identified as an appro-

priate participant in this drug treatment program, this suit would not presently be before this court.

The theory of liability against both Dr. Willis and Dr. Shovlin arises from the deficiencies in the operation of this drug treatment program. Specifically, the manner in which the program was administered delegated primary responsibility for selecting the participants in the program to ward physicians. *See Id.* at 15, 18, 19 (Findings of Fact 48, 57, 61). Neither Dr. Shovlin nor Dr. Willis instituted an adequate system through which they could ascertain the treatment status of each patient at Farview.

Dr. Shovlin, the Superintendent, did supervise the provision of care and treatment at Farview. The means he chose, however, never encompassed a systematic review of the status of each patient. Instead, the Superintendent formulated institutional policy, reviewed staff evaluations and consulted with his staff. *See Id.* at 14 (Finding of Fact 46). Dr. Willis, the Clinical Director, also supervised provision of care and treatment to patients while presiding over the staff conferences, but this type of review was neither systematic nor automatic for each patient. Referral to staff conference depended upon the initiative of the ward staff. *See Id.* at 18, 20 (Findings of Fact 58, 59, 65).

The court has no doubt that the failure to detect plaintiff's treatment needs was a proximate result of this deficiency in Farview's treatment program. Obviously, some unidentified members of the staff did not fulfill the institution's duties towards plaintiff. Since neither Dr. Willis nor Dr. Shovlin reviewed the file on each patient, they were in no position to detect these errors by the ward staff or

to make an independent determination of plaintiff's treatment and evaluation needs. That this harmful consequence flowed from the lack of a systematic review policy, however, falls short of establishing the defendants' state of mind; it is the defendants' understanding of the likelihood of those consequences that controls.

Given the conditions at Farview, even the institution of a systematic review of patient files would not have absolutely insured that each patient received all the psychiatric evaluation and treatment that he may have needed; manpower and resources at Farview were simply too scarce to guarantee that. Such a system, however, might have sufficed to insure that a modicum of the institution's treatment resources would be devoted to each patient. Drs. Shovlin and Willis made the judgment that their time was better devoted either to administrative duties in the case of Dr. Shovlin or to the staff conference system in the case of Dr. Willis than to a systematic review of each patient file.

Since Dr. Shovlin and Dr. Willis were the only physicians at Farview with extensive psychiatric experience, this decision engendered a risk that patients would be improperly evaluated by staff members with less expertise and training. Furthermore, the consequence of an erroneous evaluation by the remainder of the medical staff could be serious as plaintiff's case clearly illustrates. Nevertheless, a decision by either Dr. Shovlin or Dr. Willis to devote their time to patient file review would also have imposed burdens on the administration of the hospital. The court can hardly find that Dr. Willis or Dr. Shovlin wasted their time by devoting it to administering the facility as a whole in Dr. Shovlin's case and

to operating the staff conference system in Dr. Willis' case.

Undoubtedly, there were special circumstances at Farview that would have dictated a different allocation of time and energy for either Dr. Willis or Dr. Shovlin. *See Stuebig v. Hammel,* slip op. at 19-21 (Findings of Fact 60-66). The court would have little difficulty in finding that the increased probability of allowing a patient to go untreated, particularly in light of the severity of the consequence for that patient, would have outweighed the burden on either Dr. Shovlin or Dr. Willis of delegating some of their administrative or staff conference duties elsewhere. In short, the court believes the record supports a finding of negligence. The present action, however, would require the court to hold that this failure to delegate administrative and staff conference duties elsewhere and devote time to patient file review was so egregious as to interpret the conduct of these two physicians as exhibiting an intent to harm plaintiff or other patients at Farview. The court's judgment is that this factual record does not warrant such a finding and accordingly, the judgment in favor of Dr. Willis and Dr. Shovlin will not be altered.

3. *Harlow v. Fitzgerald*

Finally, subhequent changes in immunity law supply an alternative ground to leave the instant judgment intact. *Harlow* holds that a government official is shielded from liability for damages insofar as his conduct does not violate clearly established statutory or constitutional

rights of which a reasonable person would have known.[12] In effect, the subjective test of the *Wood* immunity standard has been eliminated. Since the present case, before *Harlow* would have been controlled by the subjective test of immunity. *Harlow* would now require a finding that immunity shields these defendants inasmuch as there were no clearly established statutory or constitutional rights to active psychiatric treatment, including a drug treatment regimen, of which they reasonably should have known.

Although plaintiff asserts that the constitutional rights at issue should be regarded as "clearly established," the court can find no merit in this contention. Throughout the later years of plaintiff's incarceration, the existence of a right to treatment was still a matter of scholarly debate. *See, e.g.,* Note, *Nascent Right to Treatment,* 53 U. Va. L. Rev. 1134 (1967); Council of the American Psychiatric Ass'n, *Position Statement on the Question of Adequacy of Treatment,* 123 Am. J. Phychiatry 1458 (1976); Note, *Liberty and Required Mental Health Treatment,* 114 U. Pa. L. Rev. 1067 (1966). The first Supreme Court case dealing with a constitutional right to treatment, *O'Connor v. Donaldson,* 422 U.S. 563 (1975), was argued and decided in the same year that plaintiff was released from Farview. The scope of treatment rights of the involuntarily committed has remained a controversial issue. *Cf. Youngberg v. Romeo,* 102 S. Ct. 2452 (1982). (Constitution guarantees right to treatment

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[12] *Harlow* unequivocally states that this alteration in the immunity defense applies to suits initiated under 42 U. S. C. § 1983 (1976). 102 S. Ct. at 2738 n. 30.

and habilitation for involuntarily committed mentally retarded).

Plaintiff argues, however, that *Harlow* should not be applied to the instant case. Since the Supreme Court cited the "substantial costs" attending the litigation of the subjective good faith of government officials as a crucial factor in its decision to broaden official immunity, 102 S.Ct. 2736-37, plaintiff contends that applying the new standard will not materially advance that interest. The court, however, notes that other courts have already applied the new standard to civil rights cases pending at the time that *Harlow* was decided. *See Saldana v. Garza,* 684 F.2d 1159, 1163-64 and nn. 15 and 16 (5th Cir. 1982); *Calloway v. Fauver,* 544 F. Supp. 584, 606-07 (D.N.J. 1982). This court also will deny the present action on the basis of *Harlow v. Fitzgerald.*

III. CONCLUSION

This case presents circumstances that, hopefully, are rare. Plaintiff has suffered deprivations of liberty that cannot be restored. Our system of justice, however, seeks to fix the obligation to pay for injury on those who bear the responsibility for inflicting that injury. The responsible parties are not before this court.

Who bears the responsibility more directly than the Commonwealth of Pennsylvania? The Commonwealth created the conditions and formulated the policy that allowed a harmless person to waste away for thirty-odd years in an institution better equipped to imprison the unfortunate than to heal the ill. At Farview, the Commonwealth charged a handful of physicians and a horde of guards with attending to hundreds of patients. To

carry out this charge, the Commonwealth endowed the institution with drugs and little else but a pair of physicians who could claim any psychiatric expertise.

Calling on the most responsible and visible officials at Farview to answer for the Commonwealth's failures is tempting. They would have had the greatest familiarity with shortcomings of the hospital. With hindsight and in a clearer legal atmosphere, one could even conclude that they accomplished something less than the best that resources would have permitted especially in allowing a long-term patient such as plaintiff to go undetected and untreated. Their knowlege and their failures, however, do not suffice to fix on them the burden of recompensing plaintiff.

None of these defendants had meaningful contact with, or exposure to, plaintiff during his stay at Farview. The physicians who attended plaintiff from the 1940's until his release have not been identified and are not before this court. No one appeared who could testify about the reasons why plaintiff received neither psychiatric treatment nor evaluation. All defendants named in this case believed they were acting reasonably and doing the best they could under the circumstances. Only a gross distortion of the facts would permit the court to conclude that plaintiff never received treatment or evaluation because any of these defendants wanted to deprive him of it. The record does show that these defendants did not knowingly act in a manner that the Constitution forbids. Such a conclusion requires the court to enter judgment in their favor.

William J. Nealon
Chief Judge, Middle District
of Pennsylvania

DATED: October 29, 1982

ORDER

In accordance with the reasoning set forth in the accompanying Memorandum, plaintiff's motions pursuant to Fed. R. Civ. P. 52(b) and 59 are hereby denied.

So ordered this 29th day of October, 1982.

William J. Nealon
Chief Judge, Middle District
of Pennsylvania

(Filed October 29, 1982)

Donald R. Berry, Clerk

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

NO. 82-3546

LAURENCE STUEBIG, a/k/a LAWRENCE STUEBIG, by his Guardian, MARIA CAROLE HECKMANN, 251 N. Bent Rd. Wyncote, Pennsylvania 19095,

Appellant

v.

ROBERT J. HAMMEL, Acting Administrator of Farview State Hospital for the Criminally Insane, Waymart, Pa.

and

BERNARD J. WILLIS, M.D., Acting Superintendent and Clinical Director of Farview State Hospital for the Criminally Insane, Waymart, Pa.

and

JOHN P. SHOVLIN, M.D., 20 Dendrick Lane, Carbondale, Pa.

and

JOHN M. FITZGERALD, Director of Social Services, Farview State Hospital for the Criminally Insane, Waymart, Pa.

and

FRANCIS TRUMAN, Captain of the Guards, Farview State Hospital for the Criminally Insane, Waymart, Pa.

and

CHARLES A. ZELLER, M.D., Former Superintendent of Farview State Hospital for the Criminally Insane, Waymart, Pa.

and

H. PROPST, M.D., 505 High Street, Honesdale, Pa. Dismissed 2/28/80

and

VINCENT P. COVOLESKIE, D.S.C., Farview State Hospital for the Criminally Insane, Waymart, Pa.

and

G. J. SALKO, M.D., Whites Crossing, Pa.

and

WILLIAM H. HORAN, M.D., Farview State Hospital for the Criminally Insane, Waymart, Pa.

and

P. POWELL, M.D., Farview State Hospital for the Criminally Insane, Waymart, Pa.

and

HERBERT L. OWNES, M.D., Farview State Hospital for the Criminally Insane, Waymart, Pa.

and

DR. FERRARO, Farview State Hospital for the Criminally Insane, Waymart, Pa.

and

J. PAUL HURST, M.D., Farview State Hospital for the Criminally Insane, Waymart, Pa.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

(C.A. No. 76-1165)

(Honorable William J. Nealon)

Argued July 21, 1983

Before: ADAMS and HIGGINBOTHAM, *Circuit Judges* and TEITELBAUM, *District Judge**

(Filed August 18, 1983)

JAMES E. BEASLEY (Argued)
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Chief, Special Litigation Section
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Office of Attorney General
Harrisburg, Pennsylvania
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*Honorable Hubert I. Teitelbaum, United States District Court for the Western District of Pennsylvania, sitting by designation.

OPINION OF THE COURT

PER CURIAM.

In 1941, Laurence Stuebig was charged with burglary with the intent to steal several boxes of candy from a railroad car. The Quarter Sessions Court of Philadelphia County found Stuebig not guilty by reason of insanity and ordered that he be detained and treated at Farview State Hospital for the Criminally Insane. Although Stuebig spent thirty-five years at Farview, his status as a mental incompetent was never reviewed and he was never treated for a psychiatric condition, which by now is incurable. In December, 1975, Stuebig was released from Farview, and shortly thereafter the Montgomery County Court of Appeals appointed Marie Carole Heckmann as his guardian.

Stuebig, by his guardian, filed a civil rights action for damages, pursuant to 42 U.S.C. § 1983, alleging that the defendants, who were officials at Farview during at least a portion of Stuebig's commitment, had violated his due process rights by neither releasing nor treating him. The district court held that, although three of the defendants named in the complaint had violated Stuebig's constitutional rights, they were immune from personal liability for damages:[1] they neither knew nor reasonably

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[1]These defendants, the appellees in the action at bar, are John Shovlin, former Farview superintendent, Bernard Willis, former clinical director, and John Fitzgerald, director of social services. The district court found insufficient evidence to link defendants Powell, Horan, and Truman to any deprivation of Stuebig's constitutional rights, and that finding is not before us on appeal. The other defendants named in the complaint were dismissed voluntarily by the plaintiff.

should have known that their failure to supervise various therapeutic programs at Farview would violate plaintiff's rights. The district court also found that the defendants did not maliciously intend to cause Stuebig injury. Chief Judge Nealon in two carefully crafted opinions determined that he was bound by recent Supreme Court decisions outlining the good-faith or qualified immunity defense of state officials sued for damages in their individual capacities. *See Harlow v. Fitzgerald,* 50 U.S.L.W. 4815 (U.S. June 24, 1982); *Youngberg v. Romeo,* 50 U.S. L.W. 4681 (U.S. June 18, 1982).

While we are greatly moved by Mr. Stuebig's plight, we are persuaded that the district court did not err in applying the law of qualified immunity. Accordingly, the judgment of the district court will be affirmed.

A True Copy:

Teste:

Clerk of the United States Court of Appeals
for the Third Circuit